State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR AIDS-RELATED CONDITION (ARC) HOME AND COMMUNITY-BASED SERVICES WAIVER

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
New Mexico Human Services Department, Medical Assistance Division (HSD/MAD) proposes amendments to the Acquired Immunodeficiency Syndrome (AIDS) or AIDS-Related Conditions (ARC) Home and Community-Based Services Waiver rules to apply the nursing facility level of care requirement and clarify qualifications of eligible providers, program services and the processes for the development of the plan of care per the newly approved waiver renewal.

VI. REGULATIONS
These proposed regulation changes will be contained in 8.314.4 NMAC (formerly MAD.735) of the Medical Assistance Program Manual. This register is available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers/2010. The proposed rule changes are attached to the register. If you do not have Internet access, a copy of the regulations may be requested by contacting the Medical Assistance Division at 827-3156.

VII. EFFECTIVE DATE
The Department proposes to implement these regulations effective December 1, 2010.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed regulations will be held at 10:00 a.m. on Thursday, October 14, 2010, in the South Park Conference Room, 2055 S. Pacheco St., Ste. 500-

590, Santa Fe, NM.
If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Kathryn Falls, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m. on October 14, 2010. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these regulations approved by:

_____

KATHRYN FALLS, SECRETARY
HUMAN SERVICES DEPARTMENT

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR AIDS-RELATED CONDITION HOME AND COMMUNITY-BASED SERVICES WAIVER

TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES-WAIVERS
PART 4 ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR AIDS-RELATED CONDITION HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.4.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.314.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 12/1/10]

8.314.4.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.314.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 12/1/10]

8.314.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. [~~See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991)~~] See NMSA 1978, Section 27-2-12 et seq.
[2/1/95; 8.314.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3 & A, 12/1/10]

8.314.4.4 DURATION: Permanent.
[2/1/95; 8.314.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 12/1/10]

8.314.4.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of the section.
[2/1/95; 8.314.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5 & A, 12/1/10]

8.314.4.6 OBJECTIVE: The objective of [~~these regulations~~] this rule is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.314.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6 & A, 12/1/10]

8.314.4.7 DEFINITIONS: [RESERVED]

8.314.4.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[2/1/95; 8.314.4.8 NMAC - Rn, 8 NMAC 4.MAD.002 & A, 12/1/10]

8.314.4.9 ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR AIDS-RELATED CONDITION HOME AND COMMUNITY-BASED SERVICES WAIVER: The New Mexico medicaid program (medicaid) pays for medically necessary services furnished to eligible recipients. To help New Mexico recipients receive necessary [~~service~~] services, the New Mexico medical assistance division (MAD) has obtained a waiver of certain federal regulations to provide home and community-based services waiver (HCBSW) programs to recipients as an alternative to institutionalization. [~~See Section 2176 of the Omnibus Budget Reconciliation Act of 1981, codified at 42 CFR 441.300 Subpart G.~~] See 42 CFR 441.300. This section describes the HCBSW services for recipients who are diagnosed as having acquired immunodeficiency syndrome (AIDS) or AIDS-related conditions (ARC), eligible providers, covered waiver services, service limitations, and general reimbursement methodology.
[2/1/95; 8.314.4.9 NMAC - Rn, 8 NMAC 4.MAD.735 & A, 12/1/10]

8.314.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, providers who meet the following requirements are eligible to be reimbursed for furnishing waiver services to recipients:

(1) meet standards established by the HCBSW program; and

(2) provide services to recipients in the same scope, quality and manner as provided to the general public; see 8.302.1 NMAC, *General Provider Policies.*

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD and the department of health (DOH). Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

C. **Qualifications of case management agency providers:** [~~Agencies must meet the standards developed for the HCBSW programs by the New Mexico department of health. Case management assessment activities necessary to establish eligibility for the waiver program are administrative costs.~~] Agencies must meet the standards developed for this HCBSW program by the applicable division of the New Mexico DOH. Case management agencies are required to have national accreditation. These accrediting organizations are the commission on accreditation of rehabilitation facilities (CARF), the joint commission or another nationally recognized accrediting authority. Case management assessment activities necessary to establish eligibility are considered administrative costs.

D. **Qualifications of case managers:** Case managers employed by case management agencies must have the skills and abilities necessary to perform case management services for recipients who are diagnosed with AIDS or ARC, as defined by the [~~HCBWS~~] HCBSW standards for this waiver program. Case managers must have one of the following credentials:

(1) bachelor's degree in social work, counseling, [~~gerontology,~~] psychology, rehabilitation counseling, nursing, or a closely related field; or

(2) licensed as a registered nurse, as defined by the New Mexico state board of nursing; or

(3) licensed as a social worker, as defined by the New Mexico board of social work examiners.

E. **Qualification of home health agency:** Agencies providing home health services must be licensed as a home health agency by the New Mexico DOH and meet the standards developed for the HCBSW programs by the New Mexico department of health.

F. **Qualifications of homemaker/personal care [~~and in-home respite care service~~] services providers:** [~~Homemaker/personal care and in-home respite care service providers must have the specific knowledge, skills and abilities to furnish services, as specified in the standards developed by the applicable HCBSW program of the department of health. For medicaid reimbursement, homemaker/personal care services providers and in-home respite care service providers must be physically and mentally able to perform tasks specified in the plan of care (POC).~~]

(1) homemaker/personal care services must be provided by a licensed home health agency, a licensed rural health clinic or a licensed or certified federally qualified health center; and

(2) homemaker/personal care services providers must have the specific knowledge, skills and abilities to furnish services, as specified in the standards developed by the applicable HCBSW program of the New Mexico DOH; for medicaid reimbursement, homemaker/personal care services providers must be physically and mentally able to perform tasks as specified in the plan of care (POC).

G. **Qualifications of private duty nursing providers:** [~~Private duty nursing services must be provided by licensed home health agencies or certified rural health clinics. Direct nursing services are provided by individuals who are currently licensed as registered or licensed practical nurses by the New Mexico state board of nursing~~] Private duty nursing services must be provided by a licensed home health agency, a licensed rural health clinic, or a licensed or certified federally qualified health center, using only registered nurses or licensed practical nurses holding a current New Mexico board of nursing license and having a minimum of one year of supervised nursing experience; nursing experience preferably with individuals who have been diagnosed with AIDS or ARC.
[2/1/95; 8.314.4.10 NMAC - Rn, 8 NMAC 4.MAD.735.1 & A, 12/1/10]

8.314.4.11 PROVIDER RESPONSIBILITIES: [~~Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See Section MAD-701, General Provider Policies. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701, General Provider Policies.~~]

A. Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies.*

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies.*
[2/1/95; 8.314.4.11 NMAC - Rn, 8 NMAC 4.MAD.735.2 & A, 12/1/10]

8.314.4.12 ELIGIBLE RECIPIENTS: Medicaid recipients diagnosed as having AIDS or ARC and who require [~~hospital or a high or low level~~] a nursing facility level of care (LOC) may be eligible to participate in the acquired immunodeficiency syndrome or AIDS-related conditions HCBSW program.
[2/1/95; 8.314.4.12 NMAC - Rn, 8 NMAC 4.MAD.735.3 & A, A, 12/1/10]

8.314.4.13 COVERED WAIVER SERVICES: This medicaid waiver covers the following services for a specified number of recipients diagnosed as having AIDS or ARC, as an alternative to institutionalization [~~in a hospital~~] , based on availability of unduplicated recipient (UDR) positions and program funding.

A. **Case management services:** Case managers provide a link between recipients and care providers and coordinate the use of community resources needed for that care. At least every month, the case manager is required to conduct a face-to-face contact with the recipient. The scope of the case manager's duties includes the following:

[~~(1) assess the recipient's medical and social needs and functional limitations, using a standardized needs assessment instrument, in cooperation with recipients, primary care givers and families;~~
~~(2) develop and implement the plan of care (POC);~~
~~(3) coordinate and monitor the delivery of services;~~
~~(4) evaluate the effectiveness of services provided under the POC and revise the plan as necessary;~~
~~(5) reassess the recipient's need for and use of HCBSW services and arrange for financial eligibility redeterminations and level of medical care determinations annually, or more frequently if necessary;~~
~~(6) mobilize the use of "natural helping" networks, such as family members, church members and friends; and~~
~~(7) provide the documentation required by the HCBSW and regular medicaid program for maintenance of accountability for services and expenditures.~~]

(1) identifying medical, social, educational, family and community support resources;
(2) scheduling and coordinating timely interdisciplinary team (IDT) meetings to develop and modify the POC annually and as needed by any team member;
(3) documenting contacts with the recipient and providers responsible for delivery of services to the recipient;
(4) verifying eligibility on an annual basis;
(5) ensuring the long-term care assessment abstract (LTCAA- ISD 379) is completed and signed by the physician, physician assistant or clinical nurse practitioner (CNP);
(6) ensuring that the comprehensive individual assessment (CIA) is completed;
(7) ensuring the timely submission of the LOC packet including the LTCAA and CIA to the third-party assessor (TPA) contractor for prior authorization;
(8) ensuring the waiver review form (MAD 046) is submitted timely, both annually and as needed;
(9) initiating an ongoing monitoring process that provides for evaluation of delivery, effectiveness, appropriateness of services and support provided to the participant as identified in the POC;
(10) performing an annual participant satisfaction survey; and
(11) coordinating services provided through the AIDS waiver and other sources (state plan, commercial insurance, educational and community).

B. **Homemaker/personal care services:** This medicaid waiver covers home/personal care services which are medically necessary and included in the recipient's POC. Homemaker/personal care services include the following duties:

[~~(1) home management and maintenance which includes promotion of self-care, house cleaning, minor home repairs;~~
~~(2) preparation of meals, including shopping, menu planning and helping the recipient eat;~~
~~(3) non-medical personal care services, including assistance with mobility, personal comfort and grooming;~~
~~(4) shopping and errands which are necessary for maintenance of the recipient at home;~~
~~(5) transportation arrangements, as indicated in the POC;~~
~~(6) emotional support;~~
~~(7) identification and reporting problems to case managers and nursing staff;~~

~~(8) health needs as specified in the POC and follow-up on health care needs; and~~
~~(9) assisting recipients with direct contact with case managers.~~]

(1) providing home management and maintenance, including budget preparation, promotion of self-care, house cleaning, dusting, mopping and vacuuming, minor home repairs, minor clothing repairs, making beds, changing linens, washing dishes, doing laundry and routine maintenance;

(2) providing meal preparation, including shopping, menu planning and assisting the recipient in eating;

(3) providing non-medical personal care services, such as assistance with mobility; personal comfort; and grooming of the recipient, including bathing, shampooing, dressing, preventive skin care and assistance with elimination;

(4) shopping and performing errands necessary for maintenance of the recipient at home;

(5) arranging for transportation or accompanying the recipient so that he/she may receive services as indicated in the POC;

(6) assisting with arrangements for health care services within the POC and following-up on health care services;

(7) teaching household members, family members or other appropriate individuals to assist with the care of the recipient;

(8) identifying and reporting problems to case managers and nursing staff; and

(9) facilitating and assisting the recipient with direct contact with the case manager.

C. **Private duty nursing:** This medicaid waiver covers medically necessary skilled private duty nursing services needed to avoid institutionalization which are provided to recipients in their own home. [~~Private duty nurses must accomplish the following:~~] Private duty nursing services are provided to a recipient at home and include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability. Services may include medication management; administration and teaching; aspiration precautions; feeding tube management such as gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health 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. The scope of the private duty nurse's duties includes:

(1) [~~initiate~~] initiating the development and implementation of the nursing treatment plan under the direction of the recipient's physician and in conjunction with the case manager in a manner that fulfills the recipient's specific needs;

(2) [~~inform~~] informing the case manager of physician-ordered changes regarding the recipient's health status;

(3) [~~ensure~~] ensuring that recipient complaints and concerns about services are reported to the case manager in a timely fashion and in a manner which directs the complaint or concern to a satisfactory conclusion;

(4) [~~report~~] reporting any situation which is or may be harmful to recipients or others to the case management agency; and

(5) [~~abide~~] abiding by the scope of practice for licensing, as defined by the New Mexico board of nursing.

[2/1/95; 8.314.4.13 NMAC - Rn, 8 NMAC 4.MAD.735.4 & A, 12/1/10]

8.314.4.14 NON-COVERED SERVICES: Only services listed as covered waiver services are covered under the HCBSW program. Ancillary services may be available to waiver recipients through the regular medicaid program. Ancillary services are subject to the limitations and coverage restrictions which exist for other medicaid services. See [~~Section MAD-602~~] 8.301.3 NMAC, *General Noncovered Services,* for general services not covered by the medicaid program.

[2/1/95; 8.314.4.14 NMAC - Rn, 8 NMAC 4.MAD.735.5 & A, 12/1/10]

8.314.4.15 PLAN OF CARE: An initial individualized plan of care (POC) must be developed by a team of professionals in consultation with [~~recipients~~] the recipient and others involved in the recipient's care within 90 days of being determined eligible for the AIDS waiver.

~~[A. The interdisciplinary team must review the treatment plan at least every six (6) months or more often if indicated.~~

~~B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documents must be available for review in the recipient's file:~~

~~(1) statement of the nature of the specific problem and the specific needs of the recipient;~~

~~(2) description of the functional level of the recipient, including an assessment and evaluation of the following:~~

~~(a) mental status assessment;~~
~~(b) intellectual function assessment;~~
~~(c) psychological assessment;~~
~~(d) educational assessment;~~
~~(e) vocational assessment;~~
~~(f) social assessment;~~
~~(g) medication assessment; and~~
~~(h) physical assessment;~~

~~(3) statement of the least restrictive conditions necessary to achieve the purposes of treatment;~~

~~(4) description of intermediate and long-range goals, with a projected timetable for their attainment and the duration and scope of therapy services;~~

~~(5) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provision for review and modification of the plan; and~~

~~(6) specification of responsibilities for areas of care, description of needs, and orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the recipient.~~]

A. The case manager assists the recipient in identifying his/her dreams, goals, preferences and outcomes for service. The case manager obtains information about the recipient's strengths, capacities, needs, preferences, desired outcomes, health status, and risk factors. This information is gained through a review of the LOC assessment; interviews between the case manager and recipient; and the person-centered planning process that takes place between the case manager and recipient to develop the POC.

B. The POC addresses: activities of daily living assistance needs, health care needs, equipment needs, relationships in the home and community, personal safety and provider responsibilities.

C. During the pre-planning process, the case manager provides the recipient with information about the AIDS waiver. The case manager provides information about the range and scope of service choices and options, as well as the rights, risks, and responsibilities associated with the AIDS waiver. The case manager then gives the recipient information about the AIDS waiver, community resources, and ways to interface with providers, physicians and support groups. The case manager is responsible for completing the CIA and obtaining other medical assessments needed for the POC; completing the annual LOC redetermination process; and referring the recipient to HSD for financial eligibility determination annually and as needed.

D. The case manager works with the recipient to identify service providers to participate in the IDT meeting. State approved providers are selected from a list provided by the case manager. The case manager encourages the recipient to meet with the provider agencies and specific providers before making a choice of agency or specific provider. The recipient sets the date and time of the IDT meeting. The case manager works with the recipient to plan the IDT meeting and encourages him/her to lead the IDT meeting to the extent possible.

E. During the IDT meeting, the case manager assists the recipient in ensuring that the POC addresses the recipient's goals, health, safety and risks along with addressing the information or concerns identified through the assessment process. The case manager writes up the POC as identified in the IDT meeting. Each provider develops care activities and strategies for each outcome, goal, and objective identified at the IDT meeting. Implementation of the POC begins when provider service plans have been received by the case manager and recipient, and the plan and budget have been approved by the TPA contractor.

F. The case manager ensures for each recipient that:

(1) the planning process addresses the recipient's needs and personal goals in medical supports needed at home for health and wellness;

(2) services selected address the recipient's needs as identified during the assessment process; needs not addressed in the POC are addressed through resources outside the AIDS waiver program;

(3) the outcomes of the assessment process for assuring health and safety are considered in the plan;

(4) services do not duplicate or supplant those available to the recipient through the medicaid state plan or other public programs;

(5) services are not duplicated in more than one service code;

(6) the parties responsible for implementing the plan are identified and listed within the document;

(7) the back-up plans are complete; and

(8) the POC is submitted to the TPA contractor in compliance with the AIDS waiver policies and procedures.

G. The POC is updated if personal goals, needs or life circumstances change that may or may not result in a change of the LOC. Revisions may be requested by the recipient. Each member of the IDT may request an IDT meeting to address changes or challenges. The case manager contacts the recipient to initiate revisions to the budget. The case manager initiates the scheduling of IDT meetings and assures the IDT meeting is in compliance with the AIDS waiver policies and procedures.

H. The case manager monitors the effectiveness of services through written reports, phone contacts, and a monthly face-to-face contact with the recipient.

I. After the initial POC, the IDT reviews the POC every six months or more often as needed, in order to assess progress toward goal achievement and determine any needed revisions in care.

[2/1/95; 8.314.4.15 NMAC - Rn, 8 NMAC 4.MAD.735.6 &, A, 12/1/10]

8.314.4.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services, including services covered [~~by the~~] under this medicaid waiver, are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, Prior [~~Approval~~] Authorization and Utilization Review. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** To be eligible for HCBSW program services, medicaid recipients must require a [~~hospital or~~] nursing facility level of care (LOC). [~~Level of care (LOC)~~] LOC determinations are made by MAD or its designee. The plan of care (POC) developed by the case manager must specify the type, amount and duration of services. Certain procedures [~~and~~] or services specified in the POC can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and [~~a~~] reconsideration. See Section MAD-953, Reconsideration of Utilization Review Decisions.

[2/1/95; 8.314.4.16 NMAC - Rn, 8 NMAC 4.MAD.735.7 & A, 12/1/10]

8.314.4.17 REIMBURSEMENT: [~~Waiver service providers must submit claims for reimbursement to the administrative services division of the department of health for processing by the MAD claims processing contractor. See Section MAD-702, Billing for Medicaid Services. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of waiver services is made at a predetermined reimbursement rate.~~] Waiver service providers must submit claims for reimbursement to the MAD medicaid management information system (MMIS) contractor for processing. Claims must be filed per the billing instructions in the medicaid policy manual. Providers must follow all medicaid billing instructions. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of waiver services is made at a predetermined reimbursement rate.

[2/1/95; 8.314.4.17 NMAC - Rn, 8 NMAC 4.MAD.735.8 & A, 12/1/10]

HISTORY OF 8.314.4 NMAC: [RESERVED]