State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
COORDINATED LONG-TERM SERVICES GENERAL PROVISIONS AND BENEFIT PACKAGE;
COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES WAIVER;
NURSING FACILITIES;
MI VIA HOME AND COMMUNITY-BASED SERVICE WAIVER

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department (the Department), Medical Assistance Division (MAD), is proposing amendments to rules 8.307.1 NMAC, *General Provisions*; 8.307.7 NMAC, *Benefit Package*; 8.307.18 NMAC, *CoLTS 1915 (C) Home and Community-Based Services Waiver*; 8.312.2 NMAC, *Nursing Facilities*; and 8.314.6 NMAC, *Mi Via Home and Community-Based Services Waiver* to implement the Centers for Medicare and Medicaid's (CMS's) Money Follows the Person (MFP) demonstration grant awarded to the State. Other changes in the rules are to update language, incorporate standardized rule language, and to provide additional clarification for providers and recipients in sections of the rules.

Money follows the person (MFP) is a demonstration grant administered by CMS. During the grant period, grantee states use available grant funding to facilitate transitions from qualified institutions to qualified community settings. MFP transition goods and services are covered under CoLTS when New Mexico has been authorized by CMS as a grantee state. MFP participants must meet specific CMS criteria referenced in the CMS grant terms and conditions and the CMS approved state MFP operational protocol. The definition for qualified eligible individuals, institutions and community settings are detailed in the operational protocol.

The proposed rule for MFP is covered in 8.307.18.13 NMAC, *Covered Waiver Services.* Money follows the person (MFP) federal demonstration grant transition goods and services: Grant funded demonstration services covered under medicaid and supplemental services that are not covered by medicaid are available to medicaid eligible recipients who are transitioning from

institutions to community settings and meet specific criteria referenced in the long-term care services utilization review instructions for nursing facility level of care. MCOs may authorize the use of MFP grant demonstration, supplemental or MCO value added transition goods and services when eligible, in coordination with the CoLTS 1915 (c) HCBS transition goods and services benefit.

VI. RULES

The definition of MFP and references to MFP are made in other related rules. The following proposed rule changes are contained in 8.307.1 NMAC, *General Provisions*; 8.307.7 NMAC, *Benefit Package*; 8.307.18 NMAC, *CoLTS 1915 (c) Home and Community-Based Services Waiver;* 8.312.2 NMAC, *Nursing Facilities;* and 8.314.6 NMAC, *Mi Via Home and Community-Based Services Waiver*. This register and the proposed changes are available on the Medical Assistance Division web site at http://www.hsd.state.nm.us/mad/registers/2012.html. If you do not have Internet access, a copy of the rules may be requested by contacting the Medical Assistance Division at 505-827-3156.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective July 1, 2012.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at 9:00 am on Wednesday, June 6, 2012 in the ASD Conference Room, 729 St. Michael's Drive, 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:

Sidonie Squier, 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 June 6, 2012. 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: Barbara.watkins@state.nm.us .

X. PUBLICATIONS

Publication of these rules approved by:

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SIDONIE SQUIER, SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 1 GENERAL PROVISIONS

8.307.1.1 ISSUING AGENCY: Human Services Department (HSD)
[8.307.1.1 NMAC - N, 8-1-08; A, 7-1-12]

8.307.1.3 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 NMSA 1978 Section 27-2-12 et. seq.~~] The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Chapter 27, Public Assistance.
[8.307.1.3 NMAC - N, 8-1-08; A, 7-1-12]

8.307.1.6 OBJECTIVE: [~~The objective of these rules is to provide policies for the service portion of the New Mexico medicaid coordination of long-term services program.~~] The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.307.1.6 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

8.307.1.7 DEFINITIONS: The state of New Mexico is committed to improving the health status of New Mexico residents whose health care services are funded by the Title XIX (medicaid) program. As a means of improving health status, a coordination of long-term services program has been implemented. This section contains the glossary for the New Mexico [~~medicaid~~] medical assistance division (MAD) coordination of long-term services policy. The following definitions apply to terms used in this chapter.

A. Definitions beginning with letter "A":

(1) **Abuse:** [~~Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to medicaid, or the interagency behavioral health purchasing collaborative (the collaborative), in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes client or member practices that result in unnecessary costs to medicaid or the collaborative.~~] Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to MAD funded programs in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes eligible recipient practices that result in unnecessary costs to MAD.

(2) **Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

(3) **Activities of daily living:** Activities necessary for daily living, including eating, dressing, oral hygiene, bathing, mobility, toileting, grooming, taking medications, transferring from a bed or chair, and walking, consistent with NMSA 1978 Section 28-17-3

(4) **Advance directive:** Written instructions relating to the provision of health services when an adult is incapacitated[~~. May~~] and may include an advance directive, mental health advance directive, living will, durable health care power of attorney, durable mental health care power of attorney, or advance health directive.

(5) **Adverse determination: [**~~A determination by coordination of long-term services managed care organization (CoLTS MCO)/single statewide entity (SE), or by its utilization review agent, that the health care services furnished or proposed to be furnished to a member are not medically necessary or are not appropriate~~] A determination by a managed care organization (MCO) or by its utilization review agent or by the SE, that the health care services furnished or proposed to be furnished to an eligible recipient are not medically necessary or are not appropriate.

(6) **ALTSD:** The New Mexico aging and long-term services department.

(7) [**~~Appeal, member:~~** ~~A request from a member or provider, on the a member's behalf with the a member's written permission, for review by the coordination of long-term services managed care organization (CoLTS MCO) or the single statewide entity (SE) for behavioral health of a CoLTS MCO/SE action as defined above in Paragraph (2) of Subsection A of 8.307.1.7 NMAC, *action*.~~] **Appeal, eligible recipient:** A request from

an eligible recipient or provider on an eligible recipient's behalf with an eligible recipient's written permission, for review by the MCO or by the SE. See 8.307.1 NMAC *General Provisions* for the definition of "action".

(8) **Appeal, provider:** A request by a provider for a review by [~~a CoLTS MCO/SE of a CoLTS MCO/SE~~] the MCO's or SE's action related to the denial of payment or an administrative denial.

(9) **Approvals:** Approvals are either initial or concurrent review decisions, which yield utilization management authorizations based on the [~~client~~] eligible recipient meeting the clinical criteria for the requested [~~medicaid~~] MAD service(s) or level of care.

(10) **Assignment algorithm:** Predetermined method for assigning mandatory enrollees who do not select [~~a CoLTS~~] an MCO.

(11) **Assisted living services:** Residential services that include personal support services, companion services, and assistance with medication administration, as set forth in department of health (DOH) rules 7.8.2 NMAC, *Residential Health Facilities* or its successor.

(12) **At risk: [**~~The period of time that a member is enrolled with a CoLTS MCO/SE, during which the CoLTS MCO/SE is responsible for providing covered services under capitation~~] The period of time that an eligible recipient is enrolled with a MCO or a SE during which the MCO or SE is responsible for providing covered services under capitation.

B. Definitions beginning with letter "B":

(1) **Begin date: [**~~The first day of the first full month following selection of or assignment to a CoLTS MCO/SE. For members who are in a nursing facility prior to the level of care determination but not enrolled in medicaid or medicare managed care, the begin date will be the first of the month in which both nursing facility level of care and medicaid eligibility exists.~~] The first day of the first full month following selection or assignment to a MCO. For an eligible recipient resident of a nursing facility (NF) prior to the level of care (LOC) determination, but not enrolled in a MAD MCO or a medicare advantage plan, the begin date will be the first month in which both the NF LOC determination and MAD eligibility exists.

(2) **Behavioral health:** [~~Refers to mental health and substance abuse.~~] A term used that includes mental health or substance abuse.

[~~(3) **Behavioral health planning council (BHPC):** Refers to the council created by HB 271 to meet federal advisory council requirements and to provide consistent, coordinated input to behavioral health service delivery in New Mexico. The SE will be expected to interact with the BHPC as an advisory council.~~

~~(4) **Behavioral health purchasing collaborative:** Refers to the interagency behavioral health purchasing collaborative pursuant to the passage of HB 271, effective May 19, 2004. The collaborative is made up of 17 publicly funded statutory member agencies, including eight agencies that provide and fund direct services, including the human services department.~~]

[~~(5)~~] (3) **Benefit package:** [~~Medicaid~~] MAD covered services that must be furnished by the [~~CoLTS MCO/SE~~] MCO or SE, and for which payment is included in the capitation rate.

C. Definitions beginning with letter "C":

(1) **Capitation:** A per-member, monthly payment to a [~~CoLTS MCO~~] MCO that covers contracted services and is paid in advance of service delivery. A set amount of money received or paid out, based on membership rather than on services delivered. It is usually expressed as "per member per month" (PM/PM).

(2) **Case:** A household that [~~medicaid~~] HSD treats as a unit for purposes of eligibility determination; for example, a parent and child; a legal guardian and child; or a set of siblings.

(3) **Case management for physical health:** [~~The targeted case management programs that are part of the medicaid benefit package. Targeted case management programs will continue to be important service components. In these programs, case managers typically function independently and assess a member's/family's needs and strengths; develop a service/treatment plan; and coordinate, advocate for and link members to all needed services related to the targeted case management program.~~] The case management programs are part of the MAD benefit package. Case management programs are important service components. In these programs, case managers typically function independently and assess an eligible recipient's or his or her family's needs and strengths; develop a service/treatment plan; and coordinate, advocate for and link an eligible recipient to all needed services related to the case management program.

(4) **Claim:** A bill for services, a line item of service, or all services for one [~~member~~] eligible recipient within a bill.

(5) **Claim dispute:** A dispute, filed by a [~~CoLTS MCO~~] MCO or SE [~~or a~~] service provider, involving payment of a claim, denial of a claim, or imposition of a sanction.

(6) **Clean claim:** A manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for

additional information from outside the health plan's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim is not materially deficient or improper, such as lacking substantiating documentation currently required by the health plan, or has no particular or unusual circumstances requiring special treatment that prevents payment from being made by the health plan within 30 calendar days of the date of receipt if submitted electronically or 45 calendar days if submitted manually.

[~~(7) **Client:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "client" may also be referred to as a "member", "customer", or "consumer".~~

~~(8) **CoLTS MCO/SE:** The use of CoLTS MCO/SE in these coordinated long-term services rules indicates the following rule applies to both the CoLTS MCO and the SE, who must each comply with the rule independent of each other.~~]

(7) **CoLTS:** The medical assistance division's coordination of long-term services program.

[~~(9)~~] (8) **CMS:** Centers for medicare and medicaid services.

[~~(10)~~] (9) **Community-based care:** A system of care that seeks to provide services to the greatest extent possible in or near the [~~member's~~] eligible recipient's home community.

[~~(11)~~] (10) **Complaint:** An expression of dissatisfaction expressed by a complainant, orally or in writing, to the [~~CoLTS MCO~~] MCO, SE or to HSD or its designee about any matter related to the [~~CoLTS MCO~~] MCO or SE other than an action. Possible subjects for complaints include, but are not limited to, the quality of care or services provided; aspects of interpersonal relationships, such as rudeness of a service provider or employee; or failure to respect [~~a member's~~] an eligible recipient's rights.

[~~(12) **Comprehensive community support services (CCSS):** These services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community.~~]

[~~(13)~~] (11) **Concurrent review:** A process of updating clinical information from a service provider to a [~~CoLTS MCO~~] MCO or SE regarding [~~a member~~] an eligible recipient who is already receiving a covered service, to evaluate whether the service continues to be medically necessary.

[~~(14) **Consumer:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "consumer" may also be referred to as a "member", "customer", "consumer", "participant", "client", or "recipient".~~

~~(15) **Member direction:** The ability of a member to be actively involved in and in control of, to the extent possible, all aspects of the member's individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.~~

~~(16)~~] (12) **Continuous quality improvement (CQI):** CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modifications of improvements, as indicated.

[~~(17)~~] (13) **Coordination of long-term services:** A coordinated program of physical health and community-based supports and services implemented under the authority of concurrent section 1915(b) and section 1915(c) waivers.

[~~(18)~~] (14) **Copayment:** A monetary amount specified by the state that the [~~member~~] eligible recipient pays directly to [~~the CoLTS MCO~~] a MCO, SE or to a service provider at the time that covered services are rendered.

[~~(19)~~] (15) **Critical incident:** A reportable incident involving an eligible recipient that may include, but is not limited to, abuse, neglect or exploitation; death; environmental hazards; law enforcement intervention; or emergency services, and which encompasses the full range of physical health, [~~medicaid~~] MAD state plan, and home and community-based services.

[~~(20)~~] (16) **Cultural competence:** A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match an individual's culture to increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which a [~~CoLTS MCO~~] MCO or SE gives another entity the authority to perform certain functions on its behalf. The [~~CoLTS MCO~~] MCO or SE retains full accountability for the delegated functions.

(2) **Denial, administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by [~~medicaid,~~] MAD, [~~not being on the CoLTS MCO formulary~~] or due to provider noncompliance with administrative policies and procedures established by [~~either~~] the [~~CoLTS MCO~~] MCO or SE or [~~the medical assistance division~~] MAD.

(3) **Denial, clinical:** A non-authorization decision at the time of an initial request for a medicaid service or a formulary exception request based on the [~~member~~] eligible recipient not meeting medical necessity for the requested service. The utilization management (UM) staff may recommend an alternative service, based on the [~~client's~~] eligible recipient's need for a lower [~~level of service~~] LOC. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

(4) **Disease management plan:** A comprehensive plan following nationally recognized components for chronic disease interventions including population identification/stratification processes, collaborative practice models, patient self-management education processes, evidence-based practice guidelines, process and outcome measurements, and internal quality improvement processes.

(5) [~~**Disenrollment, CoLTS MCO initiated:** When requested by a CoLTS MCO for substantial reason, removal of a medicaid member from membership in the requesting CoLTS MCO, as determined by HSD, on a case-by-case basis.~~] **Disenrollment, MCO initiated:** When requested by a MCO for substantial reason, removal of an eligible recipient from membership in the requesting MCO, as determined by HSD on a case-by-case basis.

(6) [~~**Disenrollment, member initiated (switch):** When requested by a member for substantial reason, transfer of a medicaid member as determined by HSD on a case-by-case basis, from one CoLTS MCO to a different CoLTS MCO during a member lock-in period.~~] **Disenrollment, eligible recipient initiated (switch):** When requested by an eligible recipient for substantial reason, transfer of an eligible recipient as determined by HSD on a case-by-case basis, from one MCO to a different MCO during a member lock-in period.

(7) **Durable medical equipment (DME):** Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is not useful to [~~individuals~~] an eligible recipient in the absence of an illness or injury, and is appropriate for use at home.

E. Definitions beginning with letter "E":

(1) **Eligible recipient:** An individual who has been determined eligible for enrollment in a medical assistance program.

[~~(1)~~] (2) **Emergency:** An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

[~~(2) **Encounter:** The record of a physical or behavioral health service rendered by a provider to a CoLTS MCO/SE member, client, customer, or consumer.~~] (3) **Encounter:** The record of a service rendered by a provider to a MCO or SE eligible recipient.

[~~(3)~~] (4) **Encounter data:** Data elements from encounters for fee-for-service or capitated service proxy claims. Encounter data elements are a combination of those elements required by HIPAA-compliant transaction formats and other data elements that comprise a [~~minimum core~~] data set.

[~~(4) **Enrollee:** A medicaid participant who is currently enrolled in a CoLTS MCO/SE coordinated long-term services program.~~

(5) [~~**Enrollee rights**: Rights that each coordination of long-term services enrollee is guaranteed.~~] **Eligible recipient rights:** Rights guaranteed by his or her MCO or SE.

(6) **Eligible recipient direction:** The ability of an eligible recipient to be actively involved in and in control of, to the extent possible, all aspects of the eligible recipient's individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.

(7) **Enhanced service:** Any service or benefit offered by the MCO or SE that is not included in the MAD benefit package or otherwise required by MAD and is not a MAD funded service, benefit or entitlement under the New Mexico Public Assistance Act. Also referred to as value added services.

[~~(6)~~] (8) **Enrollment:** The process of enrolling [~~eligible clients~~] an eligible recipient in a [~~CoLTS MCO/SE~~] MCO or SE for purposes of management and coordination of health service delivery.

[~~(7)~~] (9) **EPSDT:** Early and periodic screening, diagnostic and treatment.

[~~(8)~~] (10) **Exemption:** Removal of [~~a medicaid member~~] an eligible recipient from mandatory enrollment in coordination of long-term services, and placement in the [~~medicaid~~] MAD fee-for-service (FFS) program. Such action is only for substantial reason, as determined by HSD on a case-by-case basis.

[~~(9)~~] (11) **Expedited appeal:** A federally mandated provision for an expedited resolution within three working days of the requested appeal, which includes an expedited review by the [~~CoLTS MCO/SE~~] MCO or SE of a [~~CoLTS MCO/SE~~] MCO or SE action.

[~~(10)~~] (12) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise capable of reviewing the evidence of compliance of health care delivery and internal quality assurance/improvement requirements.

F. Definitions beginning with letter "F":

(1) **Family-centered care:** When the child is the patient, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and medical professionals, builds on individual and family strengths, and respects diversity of families.

(2) **Family planning services:** Services provided to [~~members~~] male or female eligible recipients of childbearing age to temporarily or permanently prevent or delay pregnancy (see 8.325.3 NMAC [~~MAD 762~~], *Reproductive Health Services*).

(3) **Fee-for-service (FFS):** The traditional medicaid payment method whereby payment is made by HSD to a service provider after services are rendered and billed.

(4) **Federally qualified health center (FQHC):** An entity that meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC may include an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638), or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

(5) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, a [~~CoLTS MCO/SE~~] MCO or SE, subcontractor, provider, or [~~client,~~] eligible recipient with the knowledge that the deception could result in some unauthorized benefit to himself or to some other previously described entity or person. It includes any act that constitutes fraud under applicable federal or state law.

(6) **Full benefit dual eligible:** [~~An individual enrolled in medicare and eligible for full medicaid benefits, not limited to covering costs, such as medicare premiums.~~] An individual enrolled in medicare and also is eligible for full MAD benefits.

(7) **Full risk contracts:** Contracts that place [~~the CoLTS MCO/SE~~] a MCO or SE at risk for furnishing or arranging for comprehensive services.

G. Definitions beginning with letter "G":

(1) **Gag order:** Subcontract provisions or [~~CoLTS MCO/SE~~] MCO or SE practices, either written, oral or implied, that effectively prevent a provider from furnishing accurate or complete information to [~~members~~] an eligible recipient about options for diagnosis or treatment of physical, mental or behavioral illness, injury, or condition; or prevent a provider from talking to the [~~member~~] eligible recipient or HSD about the [~~CoLTS MCO/SE~~] MCO or SE or [~~its~~] their business practices.

(2) [~~**Grievance, member:** An oral or written statement by a member recipient expressing dissatisfaction with any aspect of a CoLTS MCO/SE or its operations that is not a CoLTS MCO/SE action.~~] **Grievance, eligible recipient:** An oral or written statement by an eligible recipient expressing dissatisfaction with any aspect of a MCO or its operations but does not met the definition of "action" or "adverse determination".

(3) **Grievance, provider:** An oral or written statement by a provider to [~~the CoLTS MCO/SE~~] a MCO or SE expressing dissatisfaction with any aspect of a [~~CoLTS MCO/SE~~] MCO, SE or [~~its~~] their operations but does not met the definition of "action" or "adverse determination".

H. Definitions beginning with letter "H":

(1) **HCFA:** Health care financing administration. Effective 2001, the name was changed to centers for medicare and medicaid services (CMS).

(2) **Health plan:** A health maintenance organization (HMO), managed care organization (MCO), prepaid inpatient health plan (PIHP), or third party payer or their agents.

(3) **Hearing or fair hearing:** An administrative hearing that is held so that evidence may be presented. (See 8.352.2 NMAC, *Recipient Hearings*.)

(4) **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

(5) **Hospitalist:** A physician employed by a hospital to manage the services of [~~a member~~] an eligible recipient admitted to the hospital for inpatient services.

(6) **Human services department (HSD):** The sole executive department in New Mexico responsible for the administration of Title XIX (medicaid). "HSD" may also indicate the department's designee, as applicable.

I. Definitions beginning with letter "I":

(1) **IBNR (claims incurred but not reported):** Claims for services authorized or rendered for which the [~~CoLTS MCO/SE~~] MCO or SE has incurred financial liability, but the claim has not been received by [~~the CoLTS MCO/SE~~] a MCO or SE. This estimating method relies on data from prior authorization and referral systems, other data analysis systems and accepted accounting practices.

(2) **Individualized service plan (ISP):** An individualized service plan developed with and for [~~members who have~~] an eligible recipient who has chronic or complex conditions, and with others involved in the [~~member's~~] eligible recipient's services, to improve functional outcomes, including the standards in [~~8.314.2.15 NMAC, *individualized service plan*~~] 8.307.18 NMAC, *CoLTS 1915 (c) Home and Community Based Waiver*. An ISP includes, but is not limited to: [~~a member's~~] an eligible recipient's history; a summary of current medical and social needs and concerns; short and long-term service needs and goals; a list of services required and their frequency; and a description of who will provide the services. An ISP must be in accordance with the approved CMS coordination of long-term services home and community-based waiver program and New Mexico [~~medicaid~~] MAD state plan.

(3) **Individuals with special health care needs (ISHCN):** Individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or have low to severe functional limitation and who also require health and related services of a type or amount beyond that required by individuals generally.

J - K. [RESERVED]

L. Definitions beginning with letter "L": **Long-term services:** A continuum of services and supports for eligible recipients, ranging from in-home and community-based services for the elderly and [~~individuals~~] eligible recipients with disabilities who need help in maintaining their independence, to institutional services for those who require an institutional level of support. Throughout the continuum of long-term services and supports, the goal is to provide needed services and supports to the [~~member~~] eligible recipient while striving to maintain the [~~member's~~] eligible recipient's independence to the greatest extent possible.

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** [~~An organization licensed to manage, coordinate and assume financial risk on a capitated basis for the delivery of specified services to enrolled members from a certain geographic area. Also referred to as a managed care plan and managed care program.~~] A contracted organization licensed to manage, coordinate and assume financial risk on a capitated basis for the delivery of specified services to an enrolled eligible recipient. The MCO may be contracted specifically to provide physical health services to an eligible recipient enrolled in CoLTS as a CoLTS MCO or for behavioral health services as the single entity (SE) contracted to provide behavioral health services to an eligible recipient enrolled in CoLTS. A CoLTS MCO and the SE must each comply with the rules independently of each other.

(2) **Marketing:** The act or process of promoting a business or commodity. Marketing materials include brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, yellow page advertisements, and any other presentation materials used by a [~~CoLTS MCO/SE~~] MCO or SE, [~~CoLTS MCO/SE~~] MCO or SE representative, or [~~CoLTS MCO/SE~~] MCO or SE subcontractor to attract or retain [~~medicaid~~] MAD enrollment.

(3) **Medicaid:** The medical assistance program authorized under Title XIX of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

(4) **Medical/clinical home:** A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

(5) **Medically necessary services:**

(a) Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the [~~individual~~] eligible recipient to attain, maintain or regain functional capacity;

(ii) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the [~~individual~~] eligible recipient;

(iii) are provided within professionally accepted standards of practice and national guidelines; and

(iv) are required to meet the physical and behavioral health needs of the [~~individual~~] eligible recipient and are not primarily for the convenience of the [~~individual~~] eligible recipient, the provider or the

payer.

(b) Application of the definition:

(i) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit;

(ii) the [~~CoLTS MCO/SE~~] MCO or SE making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the [~~medicaid~~] MAD benefit package applicable to an eligible individual shall do so by; 1) evaluating individual physical and behavioral health information provided by qualified professionals who have personally evaluated the [~~individual~~] eligible recipient within their scope of practice, who have taken into consideration the [~~individual's~~] eligible recipient's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate; 2) considering the views and choices of the [~~individual or the individual's~~] eligible recipient or his or her legal guardian, agent, representative or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and 3) considering the services being provided concurrently by other service delivery systems;

(iii) physical and behavioral health services shall not be denied solely because the [~~individual~~] eligible recipient has a poor prognosis; required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible [~~individual~~] recipient solely because of the diagnosis, type of illness or condition; and

(iv) decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

(6) [~~**Member:** A client enrolled in a CoLTS MCO/SE.~~] **Member or eligible recipient direction:** The ability of an eligible recipient to be actively involved in and in control of, to the extent possible, all aspects of his or her individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.

(7) **Member month:** A calendar month during which [~~a member~~] an eligible recipient is enrolled in a [~~CoLTS MCO/SE~~] MCO or SE.

(8) **Mi via home and community-based waiver:** The mi via waiver provides self-directed home and community based services (HCBS) to eligible HCBS waiver recipients who are disabled or elderly (D&E) now CoLTS (c), developmentally disabled (DD), medically fragile (MF), those diagnosed with acquired immunodeficiency syndrome (AIDS), and those diagnosed with certain brain injuries (BI).

(9) **Money follows the person (MFP):** MFP is a demonstration grant administered by CMS. During the grant period, grantee states use available grant funding to facilitate transitions from qualified institutions to qualified community settings that are covered under CoLTS when New Mexioc has been authorized by CMS as the grantee state and when the state exercises the option to utilize the grant. MFP participants must meet specific CMS criteria referenced in the CMS grant terms and conditions and the CMS approved state MFP operational protocol (OP). The definition for qualified eligible individuals, institutions and community settings are detailed in the OP. The MCO may access the use of MFP grant demonstration, supplemental or MCO enhanced or value added transition goods and services when an eligible recipient in coordination with the CoLTS 1915 (c) HCBS transition goods and services.

N. Definitions beginning with letter "N":

(1) **National committee for quality assurance (NCQA):** A private national organization that develops quality standards for managed health care.

(2) **Network provider:** [~~An individual provider, clinic, group, association or facility employed by or contracted with a CoLTS MCO/SE to furnish medical or behavioral health services to CoLTS MCO/SE members under the provisions of the medicaid coordination of long-term services contract.~~] An individual provider, clinic, group, association or facility employed by or contracted with a MCO or SE to furnish medical services to an eligible recipient enrolled in a MCO or SE under the provisions of the MAD CoLTS or SE contract.

(3) **Non-contracted provider (non-network provider):** An individual service provider, clinic, group, association or facility that provides covered services but does not have a contract with the [~~CoLTS MCO/SE~~] MCO or SE.

(4) **Nursing facility:** A [~~medicare/medicaid~~] medicare/MAD facility licensed and certified in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to [~~members~~] an eligible recipient who require these services on a continuous basis but who [~~do~~] does not require hospital services or direct daily services from a physician.

O. [RESERVED]

P. Definitions beginning with letter "P":

[~~(1) **Participant:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "participant" may also be referred to as a "member", "customer", "consumer", "client", or "recipient".~~]

[~~(2)~~] (1) **Pend decision:** A prior authorization decision is considered pended when the decision is delayed due to lack of documentation, inability to contact parties involved or other reason which delays finalizing an approval. A decision by a [~~CoLTS MCO/SE~~] MCO or SE to pend approval does not extend or modify required utilization management decision timelines.

[~~(3)~~] (2) **Performance improvement project (PIP):** A [~~CoLTS MCO/SE~~] MCO or SE QM program activity must include projects that are designed to achieve significant improvement in clinical or non-clinical care areas. PIPs must involve measurements using objective quality indicators, system intervention to achieve improvement, evaluation of the effectiveness of interventions, and activities for increasing or sustaining improvement. Outcomes must be measurable over a period of time.

[~~(4)~~] (3) **Performance measurement (PM):** Data specified by the state that enables the [~~CoLTS MCO/SE~~] MCO or SE performance to be determined.

[~~(5)~~] (4) **Person-centered planning:** A process through which each [~~consumer or participant~~] eligible recipient is actively engaged, to the extent that the [~~consumer or participant~~] eligible recipient desires, in identifying their needs, goals and preferences, and in developing strategies to address those needs, goals and preferences.

[~~(6)~~] (5) **Plan of care:** A written document including all medically necessary services to be provided by [~~the CoLTS MCO/SE~~] a MCO or SE for a specific [~~member~~] eligible recipient.

[~~(7)~~] (6) **Policy:** The statement or description of requirements.

[~~(8)~~] (7) **Post-stabilization care services:** Services related to an emergency medical condition that are provided after [~~a member~~] an eligible recipient is medically stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR Section 438.114(b) and (e) and 42 CFR Section 422.113(c)(iii) to improve or resolve the [~~member's~~] eligible recipient's condition.

[~~(9)~~] (8) [~~**Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given coordination of long-term services program, but is not yet a member of a specific CoLTS MCO/SE.~~] **Potential MCO or SE eligible recipient:** An eligible recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given CoLTS program but is not enrolled in a specific MCO or the SE.

[~~(10)~~] (9) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

[~~(11)~~] (10) **Preventive health services:** Services that follow current national standards for prevention including both physical and behavioral health.

[~~(12)~~] (11) **Primary care:** All health services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant or certified nurse practitioner.

[~~(13)~~] (12) **Primary care case management (PCCM):** A medical care model in which [~~clients are~~] an eligible recipient is assigned to a primary care provider who is responsible for managing the quality, appropriateness, and efficiency of the care [~~they receive~~] the eligible recipient receives. The primary care provider is responsible for furnishing case management services to [~~medicaid eligible recipients~~] an eligible recipient that include the location, coordination, and monitoring of primary health care services and the appropriate referral to specialty care services.

[~~(14)~~] (13) **Primary care case manager:** A physician, a physician group practice, an entity that [~~medicaid eligible recipients employ or arrange~~] an eligible recipient employs or arranges with physicians to furnish primary care case management services or, at state option, any of the following:

(a) a physician assistant;

(b) a nurse practitioner; or

(c) a certified nurse midwife.

[~~(15)~~] (14) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to [~~members in the coordination of long-term services~~] an eligible recipient in a CoLTS program.

[~~(16)~~] (15) **Procedure:** Process required to implement a policy.

[~~(17)~~] (16) **Provider lock-in, PCP lock-in:** A situation in which [~~the CoLTS MCO/SE~~] a MCO or SE requires that [~~a member see~~] an eligible recipient see a specific identified network provider, while ensuring reasonable access to additional services, when the [~~CoLTS MCO/SE~~] MCO or SE identifies utilization of

unnecessary services or when [~~a member's~~] an eligible recipient's behavior is detrimental or indicates a need to provide case continuity.

Q. Definitions beginning with letter "Q": **Quality assurance:** A process that is adopted by a health services entity that follows written standards and criteria. The process includes the activities of a health services entity or any of its committees that: investigate the quality of health services through the review of professional practices, home and community-based service provider practices, training and experience; investigate patient cases or conduct of licensed health service providers; or encourage proper utilization of health care services and facilities. Quality assurance follows a process of discovery, both prospective and retrospective to evaluate the program; identifies areas for remediation; and implements quality improvement strategies to ensure that appropriate and timely action is taken, as indicated.

R. Definitions beginning with letter "R":

(1) **Rate cell:** A combination of category of eligibility and demographics used to isolate utilization patterns for the determination of capitation.

(2) **Received but unpaid claims (RBUC):** Claims received by the [~~CoLTS MCO/SE~~] MCO or SE but not paid, affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the [~~CoLTS MCO/SE~~] MCO or SE.

(3) **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service than were originally requested. The authorization is based on the [~~client's~~] eligible recipient's physical health (medical needs) or behavioral health (clinical needs) or long-term services needs.

(4) **Referral:** Any specialty, inpatient, outpatient, or diagnostic services that a physician or physician group orders or arranges, but does not provide directly.

(5) **Reinsurance:** Reinsurance is a proactive financial tool that may be used by a [~~CoLTS MCO/SE~~] MCO or SE to minimize exposure to losses incurred when members utilize health care services beyond anticipated levels or overall member utilization is greater than expected.

(6) **Risk:** The possibility that revenues of a [~~CoLTS MCO/SE~~] MCO or SE will not be sufficient to cover expenditures incurred in the delivery of contractual services.

(7) **Routine care:** All care that is not emergent or urgent.

S. Definitions beginning with letter "S":

(1) **Salud!:** The New Mexico physical health managed care program implemented in 1997, covering children, families, pregnant women and disabled New Mexicans. [~~Parents of medicaid-eligible children were also covered by medicaid if they met eligibility requirements.~~]

(2) S**ervice coordination:** A specialized service management that is performed by a service coordinator, in collaboration with [~~the member or the member's family or representatives~~] an eligible recipient or the eligible recipient's family member or a representative as appropriate, that is person-centered, and that includes, but is not limited to: (a) identification of the [~~member's~~] eligible recipient's needs, including physical health services, mental health services, social services, and long-term support services; and development of the [~~member's~~] eligible recipient's ISP or treatment plan to address those needs; (b) assistance to ensure timely and coordinated access to an array of providers and services; (c) attention to addressing unique needs of [~~members~~] an eligible recipient; and (d) coordination with other services delivered outside the ISP, as necessary and appropriate. Service coordination operates independently within the [~~CoLTS MCO/SE~~] MCO or SE using recognized professional standards adopted by the [~~CoLTS MCO/SE~~] MCO or SE and approved by the state, based on the service coordinator's independent judgment to support the needs of the [~~member~~] eligible recipient and is structurally linked to the other [~~CoLTS MCO/SE~~] MCO or SE systems, such as quality assurance, [~~member~~] eligible recipient services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations.

(3) **Service coordinator:** An employee or subcontractor of [~~the CoLTS MCO/SE~~] a MCO or SE with primary responsibility for providing service coordination/management to [~~members who have~~] an eligible recipient who has complex care needs including long-term service and supports or needs, or who otherwise [~~want~~] wants assistance with service planning. The service coordinator need not be a medical professional.

(4) **Single statewide entity (SE): [**~~The entity selected by the state of New Mexico through the behavioral health collaborative to perform all contract functions defined in the behavioral health request for proposals (RFP).~~] The SE is a single contractor selected to provide all defined service responsibilities statewide, including medicaid behavioral health benefits. The SE will administer both the medicaid managed care and medicaid fee-for-service (FFS) programs for all [~~medicaid~~] MAD behavioral health services. The SE [~~shall be~~] is responsible for contracting with providers, paying provider claims, assuring care coordination, conducting utilization review and utilization management activities, assuring quality review and service delivery improvement,

credentialing practitioners and provider agencies, privileging practitioners to deliver critical services or service approaches, evaluating and monitoring service delivery, and conducting any other administrative functions necessary to achieve the goals of the collaborative. The SE is the agent of the collaborative and shall "coordinate", "braid" or "blend" the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico.

(5) **Special needs individual:** A medicare advantage (MA) eligible individual who is institutionalized, is entitled to medical assistance under a state plan under Title XIX, or has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized MA plan.

(6) **Special needs plan:** A specialized MA coordinated service plan for special needs individuals that exclusively or disproportionately serves special needs individuals.

(7) **State plan:** A statewide plan for [~~medicaid~~] MAD eligibility and services submitted for approval to CMS under Title XIX of the federal Social Security Act.

(8) **Subcontract:** A written agreement between a [~~CoLTS MCO/SE~~] MCO or SE and a third party, or between a subcontractor and another subcontractor, to provide services.

(9) **Subcontractor:** A third party who contracts with a [~~CoLTS MCO/SE~~] MCO or SE or a [~~CoLTS MCO/SE~~] MCO or SE subcontractor for the provision of services.

(10) **Suspension or suspended provider:** A service provider that has been convicted of a program-related offense in a federal, state or local court. Items or services furnished by a suspended provider will not be reimbursed under [~~medicaid~~] MAD.

T. Definitions beginning with letter "T":

(1) **Terminations of care:** The utilization management review decision made during a concurrent review that yields a denial based on the current service being no longer medically necessary.

(2) **Third party:** An individual entity or program that is or may be, liable to pay all or part of the expenditures for [~~medicaid members for services furnished under a state plan~~] an eligible recipient's services.

(3) **Tribal facility 638:** A facility operated by a Native American or Indian tribe authorized to provide services pursuant to the Indian Self-Determination and Education Assistance Act.

(4) **Tribal provider or Indian health service (IHS) provider:** A facility that is operated by a Native American/Alaskan Indian tribe authorized to provide services as defined in the Health Care Improvement Act, 25 USC Section 1601, et seq.

U. Definitions beginning with letter "U":

(1) **Urgent condition:** Acute signs and symptoms that, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

(2) **Utilization management:** A system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a member.

V. [~~Definitions beginning with letter "V": **Value-added service:** Any service or benefit offered by the CoLTS MCO/SE that is not included in the coordination of long-term services benefit package and is not a medicaid funded service, benefit or entitlement under the New Mexico Public Assistance Act.~~] [RESERVED]

W. Definitions beginning with letter "W": **Waiver program:** One or more of the state of New Mexico [~~medicaid~~] MAD home and community-based services waiver programs.

X - Z. [RESERVED]

[8.307.1.7 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

8.307.1.8 MISSION STATEMENT: [~~The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.~~] To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.307.1.8 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

HISTORY OF 8.307.1 NMAC [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 18 COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES WAIVER

8.307.18.6 OBJECTIVE: [~~The objective of this rule is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, provider responsibilities, eligible recipients, covered services, non-covered services, ISP, prior authorization and utilization review and provider reimbursement.~~] The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.307.18.6 NMAC - N, 12-15-10; A, 7-1-12]

8.307.18.8 MISSION STATEMENT: [~~The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.~~] To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.307.18.8 NMAC - N, 12-15-10; A, 7-1-12]

8.307.18.9 COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES WAIVER (CCW): [~~To help New Mexicans who are disabled or elderly receive services in a cost-effective manner, HSD, medical assistance division (MAD or medicaid) has obtained a home and community-based services (HCBS) waiver, formerly known as the disabled and elderly (D&E) HCBS waiver, now called coordinated long-term care services waiver. The CoLTS 1915 (c) waiver (CCW) provides home and community-based services to eligible recipients who are disabled or elderly, as an alternative to institutionalization. This waiver program is offered under the coordination of long term services (CoLTS) program. The CoLTS program is administered by HSD/MAD through contracts with managed care organizations (MCOs). The CoLTS MCO's are responsible for providing service coordination to waiver recipients.~~] To assist New Mexicans, the medical assistance division (MAD) administers the CoLTS 1915 (c) waiver (CCW). The CCW provides home and community-based services to eligible recipients who are disabled or elderly, as an alternative to institutional residency.
[8.307.18.9 NMAC - N, 12-15-10; A, 7-1-12]

8.307.18.10 ELIGIBLE PROVIDERS:

A. [~~Eligible independent providers and provider agencies must be approved by medicaid or medicaid's designee, the CCW state operating agency, aging and long-term services department/elderly and disabilities services division (ALTSD/EDSD). The provider must have an approved medicaid provider participation agreement with medicaid and an approved provider agreement with ALTSD/EDSD.~~] Eligible independent providers and provider agencies must have been approved by MAD or its designee. The provider must have an approved MAD provider participation agreement with MAD or its designee.

B. Individual service providers participate as employees or contractors of approved agencies, except as otherwise recognized by these [~~regulations~~] rules. Providers may subcontract only with individuals who are qualified and must follow the general contract provisions for subcontracting.

C. Providers are required to follow state licensing regulations, as applicable. This includes, but is not limited to nurses, social workers, physical therapists (PTs), physical therapy assistants (PTAs), occupational therapists (OTs), certified occupational therapy assistants (COTAs), and speech language pathologists (SLPs). Refer to the New Mexico regulation and licensing department for information regarding applicable licenses.

D. Once enrolled, providers receive information including medicaid program policies, and other pertinent materials from [~~medicaid and ALTSD/EDSD~~] MAD. As [~~medicaid or ALTSD send~~] MAD sends new materials, providers are responsible for ensuring they receive, read and adhere to information contained in the materials.

E. [~~**Qualifications of**~~**] Requirements for home health care agencies that provide private duty nursing and respite services through the waiver:**

(1) Services [~~may~~] can be provided [~~by~~] only through eligible agencies.

(2) Agencies [~~may~~] must be licensed by the department of health (DOH) as a home health agency pursuant to state law.

(3) [~~Providers~~] A provider must:

(a) comply with all applicable federal, and state waiver regulations [~~and service standards~~] regarding services;

(b) [~~provide supervision to each respite staff at least quarterly, depending on the amount of respite used; supervision must include an on-site observation of the services provided and a face-to-face interview of the individual being served; and~~] provide supervision to each respite staff at least quarterly including an on-site observation of the services provided and a face-to-face interview of the eligible recipient being served; and

(c) comply with the Department of Health Act, NMSA 1978, Section 9-7-1, et seq. and the Employee Abuse Registry Act, NMSA 1978, Sections 27-7A-1, et seq.

(4) Providers must have available and maintain a roster of trained and qualified employees for back-up of regular scheduling and emergencies.

(5) [~~Providers~~] A provider must ensure that each staff meets the following requirements:

(a) completes a services training program that may include, but is not limited to, agency in-service training or continuing education [~~classes;~~] classes and that all training [~~must be~~] is documented [~~as required in ALTSD/EDSD CCW service standards; and the following~~].

(i) new staff must complete 10 hours of training prior to providing services;

(ii) following the first year of service provision, staff must complete a minimum of 10 hours of training annually;

(iii) new staff must complete a written competency test that demonstrates the skill and knowledge required to provide services with a minimum passing score of 85 percent or better, prior to or within 30 days of providing services; and

(iv) staff assigned to new clients must receive instructions specific to the individual recipient prior to providing services to the recipient;

(b) possesses a minimum of one year experience as an aide in a hospital, nursing facility (NF) or rehabilitation center; or two years experience in managing a home or family;

(c) successfully passed nationwide criminal history screening pursuant to 7.1.9 NMAC and in accordance with the Caregivers Criminal History Screening Act, NMSA 1978, Section 29-17-1, et seq.; documentation that the screen has been successfully passed must be maintained in the employee's personnel file;

(d) a current tuberculin (TB) skin test or a chest x-ray upon initial employment by the provider as defined by the DOH; a copy of these results must be maintained in the employees personnel file;

(e) a current cardiopulmonary resuscitation (CPR)/heart saver certification; a copy of this certification must be maintained in the employee's personnel file;

(f) a current first aid certification; a copy of this certification must be maintained in the employee's personnel file; and

(g) a valid state driver's license and a motor vehicle insurance policy if the eligible waiver recipient is to be transported by staff; copies of the driver's license and motor vehicle insurance policy must be maintained in the employee's personnel [~~file; and~~] file.

[~~(h) other qualifications set forth in the CCW service standards.~~]

F. [**~~Qualifications of~~**] **Requirements for skilled maintenance therapy provider agencies:** Skilled maintenance therapy includes PT for adults, OT for adults, and speech and language therapy (SLT) for adults.

(1) Skilled maintenance therapy services [~~may~~] must be provided by eligible skilled maintenance therapy agencies or independent therapists.

(2) [~~Physical,~~] A physical, occupational and speech and language [~~therapists, and PTAs~~] therapist and a physical therapist assistant (PTA) must possess a therapy license in their respective field from the New Mexico regulation and licensing department. [~~COTAs~~] A certified occupational therapist assistant (COTA) must possess an occupational therapy assistant certification from the New Mexico regulation and licensing department. [~~Speech~~] A speech clinical [~~fellows~~] fellow must possess a clinical fellow license from the New Mexico regulation and licensing department.

(3) Skilled maintenance therapy providers must:

(a) comply with all applicable federal and state waiver regulations and service standards regarding therapy services;

(b) ensure that all PTAs, COTAs and speech clinical fellows are evaluated by a licensed therapist supervisor licensed in the same field at least monthly in the setting where therapy services are provided; bi-monthly supervision must be provided;

(c) ensure all therapy services are provided under the order of the eligible waiver recipient's primary care provider; the therapy provider will obtain the order; the original of this order must be maintained by the therapy provider in the recipient's therapy file and the therapy provider must give a copy of the order to the service coordinator; and

(d) meet all other qualifications set forth in the CCW service standards.

[~~G. **Qualifications for assisted living facilities:**~~

~~(1) Assisted living services may be provided by an eligible assisted living facility.~~

~~(2) Assisted living service provider agencies must be licensed as an assisted living facility.~~

~~(3) Assisted living facilities must:~~

~~(a) meet all the requirements and regulations, and be licensed by DOH as an adult residential care facility pursuant to 7.8.2 NMAC;~~

~~(b) provide a home-like environment; and~~

~~(c) comply with the provisions of Title II and III of the Americans with Disabilities Act (ADA) of 1990, (42 U.S.C. Section 12101, et seq.).~~

~~(4) Assisted living facilities must:~~

~~(a) comply with all applicable federal, state and waiver regulations and service standards regarding services;~~

~~(b) ensure that individuals providing direct services meet all requirements for service provision;~~

~~(c) ensure that individuals providing private duty nursing and skilled therapy services meet all requirements for these services if provided; and~~

~~(d) meet all other qualifications set forth in the CCW service standards.~~]

G. **Requirements for assisted living facilities:**

(1) Assisted living services can be provided only by an eligible assisted living facility.

(2) An assisted living facility must:

(a) meet all the requirements and regulations, and be licensed by DOH as an adult residential care facility pursuant to 7.8.2 NMAC;

(b) provide a home-like environment; and

(c) comply with the provisions of Title II and III of the Americans with Disabilities Act (ADA) of 1990, (42 U.S.C. Section 12101, et seq.).

(3) An assisted living facility must:

(a) comply with all applicable federal, state and waiver regulations and service standards regarding services;

(b) ensure that individuals providing direct services meet all requirements for service provision; and

(c) ensure that individuals providing private duty nursing and skilled therapy services meet all requirements for these services if provided.

[~~(d) meet all other qualifications set forth in the CCW service standards.~~]

H. [~~**Qualifications of**~~**] Requirements for adult day health provider agencies:**

(1) Adult day health services [~~may~~] can be provided only by eligible adult day health agencies.

(2) Adult day health facilities must be licensed by DOH as an adult day care facility.

(3) Adult day health facilities must meet all requirements and regulations set forth by DOH as an adult day care facility.

(4) [~~Adult~~] An adult day health care provider [~~agencies~~] agency must comply with the provisions of Title II and III of the Americans with Disabilities Act of 1990, (42 U.S.C. Section 12101, et seq.).

(5) [~~Adult~~] An adult day health care provider [~~agencies~~] agency must comply with all applicable city, county or state regulations governing transportation services.

[~~(6) Adult day health care provider agencies must meet all other qualifications set forth in the CCW service standards.~~]

I. [~~**Qualifications**~~**] Requirements for environmental modifications providers:**

(1) Environmental modification services [~~may~~] can be provided only by eligible environmental modification agencies.

(2) [~~Environmental modification providers~~] An environmental modification provider must have valid New Mexico regulation and licensing department, construction industries division, GB-2 class construction license pursuant to the Construction Industries Licensing Act NMSA 1978, Section 60-13-1 et seq.

(3) [~~Environmental modification providers~~] An environmental modification provider must:

(a) comply with all New Mexico state laws, rules, and regulations, including applicable building codes, and the laws and regulations of the Americans with Disability Act Accessibility Guidelines (ADAAG), the Uniform Federal Accessibility Standards (UFAS), and the New Mexico state building code;

(b) provide at minimum a one-year warranty on all parts and labor; and

[~~(c) meet all other qualifications set forth in the CCW service standards.~~]

J. [~~**Qualifications**~~**] Requirements for emergency response providers:**

(1) Emergency response services [~~may~~] can be provided only by eligible emergency response agencies.

(2) [~~Emergency response providers~~] An emergency response provider must comply with all laws, rules and regulations of the New Mexico state public corporation commission for telecommunications and security systems, if applicable.

[~~(3) Emergency response providers must meet all other qualifications set forth in the CCW service standards.~~]

[8.307.18.10 NMAC - N, 12-15-10; A, 7-1-12]

8.307.18.11 PROVIDER RESPONSIBILITIES:

[~~A. Providers who furnish services to medicaid recipients must comply with all medicaid provider participation requirements as outlined in 8.302.1 NMAC, *General Provider Policies*.~~

~~B. Verify every month that each recipient is eligible for full medicaid coverage and CCW services prior to providing services pursuant to Subsection A of 8.302.1.11 NMAC, *General Provider Policies*; providers must document the date and method of eligibility verification (i.e. HSD/medicaid contracted agency's automated voice response system (AVRS), or eligibility help desk); 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 individual's financial eligibility; agencies that provide CCW services to individuals who are not medicaid or CCW eligible cannot bill medicaid for the services provided to the individual.~~

~~C. Maintain records that are sufficient to fully disclose the extent and nature of the services provided to the individual as outlined in 8.302.1 NMAC, *General Provider Policies*.~~

~~D. Comply with random and targeted audits conducted by the department or its designee that ensure providers are billing appropriately for services provided; the department or its designee will seek recoupment of funds from providers when audits show inappropriate billing for services.~~

~~E. Comply with DOH incident reporting and investigation requirements for providers of community based services pursuant to 7.1.13 NMAC.~~

~~F. Maintain a continuous quality management program with annual reports of the program implementation and outcomes. Reports must be submitted to ALTSD pursuant to CCW regulations herein.~~]

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. A MAD CCW provider must comply with all applicable federal regulations, MAD rules regarding the provision of covered waiver services and investigation requirements for providers of community based services pursuant to 7.1.13 NMAC or its successor.

D. Comply with DOH incident reporting.

E. Maintain a continuous quality management program with annual reports of the program implementation and outcomes. Reports must be submitted to MAD or its designee. See 8.302.1 NMAC, *General Provider Policies*.

[8.307.18.11 NMAC - N, 12-15-10; A, 7-1-12]

8.307.18.12 ELIGIBLE RECIPIENTS:

[~~A. The program is limited to the number of federally authorized unduplicated recipient (UDR) positions and program funding.~~

~~B. CCW services are limited to individuals who have received an allocation for CCW services and who meet institutional LOC criteria and institutional financial criteria as determined by HSD. Pursuant to 8.290.400.10 NMAC, *basis for defining the group*.~~

~~C. In addition to meeting institutional criteria specified above, individuals must meet the following requirements to be eligible for CCW services:~~

~~(1) persons who are elderly (age 65 or older), or persons aged birth to 64 with a disability (blind or disabled) as determined by the disability determination unit utilizing social security disability guidelines, who reside in the community; or~~

~~(2) persons who are elderly (age 65 or older), or persons aged birth to 64 with a disability (blind or disabled as determined by the disability determination unit utilizing social security disability guidelines), who are institutionalized and want to return to community living or are at risk of institutionalization.~~]

A. CCW services are limited to the number of federally authorized unduplicated recipient (UDR) positions (slots) and program funding. Financial, non-financial and medical factors are used by HSD to determine an recipient's CCW eligibility. See: 8.200.400 NMAC through 8.200.500 NMAC, *Medicaid Eligibility-General Recipient Policies*, 8.290.500 NMAC through 8.290.600 NMAC, *Home and Community Based Waiver Services (Categories 090, 091, 092, 093, 094, 095, 096)* and long term care services utilization review instructions for nursing facility (NF) level of care (LOC) located on the HSD/MAD website.

B. CCW services are provided to an eligible recipient who is enrolled in the CCW program.

C. In addition to meeting eligibility criteria specified above, an eligible recipient must be elderly (age 65 or older), or have a disability (blind or disabled) as determined by the disability determination unit utilizing social security disability guidelines, including duration and prognosis with respect to ability to be employed, and require a NF LOC or is currently residing in an institutional facility and is requesting a return to community living.

[8.307.18.12 NMAC - N, 12-15-10; A, 7-1-12]

8.307.18.13 COVERED WAIVER SERVICES: [~~All CCW providers must comply with all applicable federal and state waiver regulations and service standards regarding the provision of covered waiver services. The CCW covers the following services for a specified and limited number of waiver recipients as a cost effective alternative to institutionalization in a NF.~~

~~A. Service coordination operates independently within the CoLTS MCO using recognized professional standards adopted by the CoLTS MCO and approved by the state, based on the service coordinator's independent judgment to support the needs of the member and is structurally linked to the other CoLTS MCO systems, such as quality assurance, member services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations. The CoLTS MCO's service coordinator, who has experience in working with the elderly, individuals with disabilities, and others in need of long-term services, is responsible for ensuring that all applicable policies and procedures involving service plan development are followed. Service coordinators can be RNs, LPNs, social workers, or individuals with at least a bachelor's degree in counseling, special education or a closely related field. Service coordination activities include specialized service management that is performed by a service coordinator, in collaboration with the member or the member's family or representatives as appropriate, which is person-centered, and includes, but is not limited to:~~

~~(1) identification of the member's needs, including physical health services, mental health services, social services, and long-term support services; and development of the member's ISP or treatment plan to address those needs;~~

~~(2) assistance to ensure timely and coordinated access to an array of providers and services;~~

~~(3) attention to addressing unique needs of members; and~~

~~(4) coordination with other services delivered in addition to those noted in the ISP, as necessary and appropriate.~~

~~B. **Private duty nursing services for adults:** Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness or chronic disability.~~

~~(1) Services include the following:~~

~~(a) medication management, administration and teaching;~~

~~(b) aspiration precautions;~~

~~(c) feeding tube management;~~

~~(d) gastrostomy and jejunostomy;~~

~~(e) skin care and wound care;~~

~~(f) weight management;~~

~~(g) urinary catheter management and bowel and bladder care;~~

(h) health education;
(i) health screening;
(j) infection control and environmental management for safety;
(k) nutrition management;
(l) oxygen management;
(m) seizure management and precautions;
(n) anxiety reduction;
(o) staff supervision; and
(p) behavior and self-care assistance.

(2) Private duty nursing services must be provided under the order and direction of the recipient's primary care provider, in accordance with the New Mexico Nursing Practice Act NMSA 1978, Section 61-3-1 et seq. and in conjunction with the interdisciplinary team and the service coordinator.

(3) Private duty nursing services must be provided in accordance with all applicable federal and state program regulations and ALTSD/EDSD CCW service standards. Children receive this service through the medicaid early periodic screening, diagnosis and treatment (EPSDT) program.

C. **Respite services:** Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of the unpaid primary caregiver normally providing the care.

(1) Respite services may consist of non-nursing services or private duty nursing services, based on the recipient's needs.

(2) Respite services may be provided in a participant's home, the respite provider's home, or the community.

(3) Services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities, and allowing community integration opportunities.

(4) Respite services are limited to a maximum of 100 hours annually per ISP year.

D. **Skilled therapy services for adults:** Skilled maintenance therapy services for adults include PT, OT and SLT services. Children receive this service through the medicaid EPSDT program.

(1) PT promotes gross or fine motor skills, facilitates independent functioning or prevents progressive disabilities.

(a) Specific services may include:
(i) professional assessment(s), evaluations and monitoring for therapeutic purposes;
(ii) PT treatment interventions;
(iii) training regarding PT activities;
(iv) use of equipment and technologies or any other aspect of the individual's PT services;
(v) designing, modifying or monitoring use of related environmental modifications;
(vi) designing, modifying and monitoring use of related activities supportive to the ISP goals and objectives; and
(vii) consulting or collaborating with other service providers or family members, as directed by the participant.

(b) PT services must be provided in accordance with all applicable federal and state waiver program regulations and ALTSD/EDSD CCW service standards.

(2) OT promotes fine motor skills, coordination, sensory integration, facilitates the use of adaptive equipment or other assistive technology, facilitates independent functioning, and prevents progressive disabilities.

(a) Specific services may include:
(i) teaching daily living skills;
(ii) developing perceptual motor skills and sensory integrative functioning;
(iii) designing, fabricating or modifying assistive technology or adaptive devices;
(iv) providing assistive technology services;
(v) designing, fabricating or applying selected orthotic or prosthetic devices or selecting adaptive equipment;
(vi) using specifically designed crafts and exercise to enhance function;
(vii) training regarding OT activities; and
(viii) consulting or collaborating with other service providers or family members, as directed by the participant.

(b) OT services must be provided in accordance with all applicable federal, state and waiver program regulations, policies and procedures, and ALTSD/EDSD CCW service standards.

(3) SLT preserves abilities for independent function in communication, facilitates oral motor and swallowing function, facilitates use of assistive technology, and prevents progressive disabilities.

(a) Specific services may include:

(i) identifying communicative or oropharyngeal disorders and delays in the development of communication skills;

(ii) preventing communicative or oropharyngeal disorders and delays in the development of communication skills;

(iii) developing eating or swallowing plans and monitoring their effectiveness;

(iv) using specifically designed equipment, tools, and exercises to enhance function;

(v) designing, fabricating or modifying assistive technology or adaptive devices;

(vi) providing assistive technology services;

(vii) adapting the participant's environment to meet his needs;

(viii) training regarding SLT activities; and

(ix) consulting or collaborating with other service providers or family members, as directed by the participant.

(b) SLT services must be provided in accordance with all applicable federal and state waiver program regulations and ALTSD/EDSD CCW service standards.

E. **Assisted living services:** Assisted living is a residential service that includes assistance with activities of daily living (ADL) services, companion services, medication management (to the extent required under state law; medication oversight as required by state law), 24-hour on-site response capability to meet scheduled or unpredictable participant needs, and to provide supervision, safety and security. Services also include social and recreational programming.

(1) Coverage does not include 24-hour skilled care or supervision.

(2) Rates for room and board are excluded from the cost of services and are either billed separately by the provider or an itemized statement is developed that separates the costs of waiver services from the costs of room and board.

(3) Nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. Nursing and skilled therapy services may be provided by third parties and must be coordinated with the assisted living facility.

(4) Assisted living facilities must enter into an agreement with the recipient that details all aspects of care to be provided including identified risk factors. The original agreement must be maintained in the recipient's file and a copy must be provided by the assisted living facility to the service coordinator.

(5) Assisted living services must be provided by an assisted living facility that has been licensed and certified by DOH as an adult residential care facilities, pursuant to 7.8.2 NMAC and all other applicable federal and state waiver program regulations and ALTSD/EDSD CCW service standards.

F. **Adult day health services:** Adult day health services offer health and social services to assist participants to achieve optimal functioning and activates, motivates and rehabilitates the participant in all aspects of their physical and emotional well-being, based on the recipient's individual needs.

(1) Services include:

(a) a variety of activities for recipients that promote personal growth and enhance the recipient's self-esteem by providing opportunities to learn new skills and adaptive behaviors, improve capacity for independent functioning, or provide for group interaction in social and instructional programs and therapeutic activities; all activities must be supervised by program staff;

(b) supervision of self-administered medication as determined by the New Mexico Nursing Practice Act NMSA 1978, Section 61-3-1, et seq.;

(c) involvement in the greater community;

(d) transportation to and from the adult day health program; and

(e) meals that do not constitute a "full nutritional regime" of three meals per day.

(2) 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, community based facility.

(3) The provider must assure safe and health conditions for activities inside or outside the facility.

(4) Adult day health services include nursing services and skilled maintenance therapies (physical, occupational and speech) that must be provided in a private setting at the facility. The nursing and skilled

maintenance therapies do not have to be directly provided by the facility. If directly provided, the facility must meet all program requirements for the provision of these services.

(5) Adult day health services must be provided as set forth by DOH as an adult day health facility, pursuant to 7.13.2 NMAC and all other applicable federal and state waiver program regulations and ALTSD/EDSD CCW service standards.

G. **Environmental modification services:** Environmental modifications services include the purchase and installation of equipment and making physical adaptations to an individual's residence that are necessary to ensure the health, welfare and safety of the individual or enhance the individual's level of independence.

(1) Adaptations include the following:

(a) installation of ramps and grab bars;

(b) widening of doorways or hallways;

(c) installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;

(d) purchase and installation of lifts or elevators;

(e) modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing);

(f) turnaround space adaptations;

(g) specialized accessibility, safety adaptations and additions;

(h) installation of trapeze and mobility tracks for home ceilings;

(i) purchase and installation of automatic door openers or doorbells, voice-activated, light-activated, motion-activated and electronic devices;

(j) fire safety adaptations;

(k) purchase and installation of modified switches, outlets or environmental controls for home devices;

(l) purchase and installation of alarm and alert systems or signaling devices;

(m) air filtering devices;

(n) heating/cooling adaptations; and

(o) glass substitute for windows and doors.

(2) Service coordinators must consider alternative methods of meeting the individual's needs prior to listing environmental modifications on the ISP.

(3) Environmental modifications have a limit of $5,000 every five years.

(4) The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction or remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the individual's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

(5) The environmental modification provider must submit the following information as required by ALTSD/EDSD CCW service standards:

(a) an environmental modification evaluation;

(b) a service cost estimate including equipment, materials, supplies, labor, travel, per diem;

(c) a letter of acceptance of service cost estimate signed by the recipient;

(d) a letter of permission from owner of property;

(e) a construction letter of understanding;

(f) photographs of the proposed modification; and

(g) documentation demonstrating compliance with the American with Disabilities Act Accessibility Guidelines (ADAAG), the uniform federal accessibility standards (UFAS), and the New Mexico state building code.

(6) After the completion of work, the environmental modification provider must submit the following to the MCO:

(a) a letter of approval of work completed, signed by the recipient; and

(b) photographs of the completed modifications.

(7) Environmental modification services must be managed by professional staff available to provide technical assistance and oversight for environmental modification projects.

(8) Environmental modification services shall be provided in accordance with all applicable federal and state waiver program regulations including applicable federal, state and local building codes, and ALTSD/EDSD CCW service standards.

H. **Emergency response services:** Emergency response services provide an electronic device that enables a participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center when a "help" button is activated. The response center reacts to the signal to ensure the recipient's health and safety.

(1) Emergency response services include:

(a) testing and maintaining equipment;

(b) training participants, caregivers and first responders on use of the equipment;

(c) 24 hour monitoring for alarms;

(d) checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and

(e) reporting participant emergencies and changes in the participant's condition that may affect service delivery.

(2) The response center must be staffed by trained professionals.

(3) Emergency response service categories consist of emergency response and emergency response high need.

(4) Emergency response providers shall provide the recipient with information regarding services rendered, limits of services and information regarding agency service contracts.

(5) Emergency response providers must report recipient emergencies and changes in the recipient's condition that may affect service delivery to the MCO within 24 hours.

(6) Emergency response providers must complete quarterly reports for each recipient served. The original report must be maintained in the recipient's file and a copy must be submitted by the emergency response provider to the MCO.

(7) Emergency response services shall be provided in accordance with all applicable federal and state waiver program regulations and ALTSD/EDSD CCW service standards.

I. **Service coordination**: Service coordination operates independently within the CoLTS MCO using recognized professional standards adopted by the CoLTS MCO and approved by the state, based on the service coordinator's independent judgment to support the needs of the member and is structurally linked to the other CoLTS MCO systems, such as quality assurance, member services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations. The CoLTS MCO's service coordinator, who has experience in working with the elderly, individuals with disabilities, and others in need of long-term services, is responsible for ensuring that all applicable policies and procedures involving service plan development are followed. Service coordinators can be RNs, LPNs, social workers, or individuals with at least a bachelor's degree in counseling, special education or a closely related field. Service coordination activities include specialized service management that is performed by a service coordinator, in collaboration with the member or the member's family or representatives as appropriate, which is person-centered, and includes, but is not limited to:

(1) identification of the member's needs, including physical health services, mental health services, social services, and long-term support services; and development of the member's ISP or treatment plan to address those needs;

(2) assistance to ensure timely and coordinated access to an array of providers and services;

(3) attention to addressing unique needs of members; and

(4) coordination with other services delivered in addition to those noted in the ISP, as necessary and appropriate.

J. **Community transition goods and services:**

(1) Community transition goods and services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement (excluding assisted living facilities) to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

(a) security deposits that are required to obtain a lease on an apartment or home;

(b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;

~~(c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;~~

~~(d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;~~

~~(e) moving expenses;~~

~~(f) necessary home environmental modifications provided no more than 180 days prior to transition;~~

~~(g) specialized medical equipment and supplies not otherwise covered by medicaid and purchased within 60 days of the scheduled transition;~~

~~(h) assistive technology and durable medical equipment not otherwise covered by medicaid purchased within 60 days of the scheduled transition;~~

~~(i) nutrition support services such as short-term nutritional counseling and education in food preparation skills;~~

~~(j) non-medical transportation;~~

~~(k) non-medical transportation supports such as vehicle modification;~~

~~(l) family services to support or educate the informal support network; and~~

~~(m) the purchase and related costs of service animals up to service limits.~~

~~(2) Community transition goods and services are furnished only to the extent that the goods or services:~~

~~(a) are reasonable and necessary as determined through the service plan development process;~~

~~(b) are clearly identified in the service plan;~~

~~(c) cannot be obtained from other sources;~~

~~(d) are not prohibited by federal and state statutes and regulations;~~

~~(e) are not experimental in nature; and~~

~~(f) the person has no other access to these services.~~

~~(3) Community transition goods and services do not include monthly rental or mortgage expense, food, regular utility charges, or household appliances or items that are intended for purely diversion/recreation purposes.~~

~~(4) Community transition goods and services are limited to $3,500.00 per person every five years. In order to be eligible for this service, the person must have a NF stay at least 30 days prior to transition to the community.~~

~~K. C~~**~~ommunity relocation specialist services:~~** ~~The CoLTs MCOs are responsible for designation and oversight of the community transition relocation specialist. Community transition relocation specialist services are specialized services, provided while the person is in the NF and during the first 60 days of transition to the community, to assess the person's needs, complete a service plan, assist the person to arrange for and procure needed resources for the move from the nursing facility to the community, and monitor transition service delivery, provided the service is provided no more than 60 days for waiver participant's who have been institutionalized for more than six months, or 14 days for those who have been in the institution for less than six months.~~

~~(1) The relocation specialist educates the consumer/participant about home and community-based service options, the transition process, and other relevant issues. The relocation specialist works with the consumer/participant, the consumer/participant's support network when applicable and the consumer/participant's CoLTS MCO service coordinator to develop a person-centered, community-based transition plan as part of the consumer/participant's individual service plan (ISP) that includes a detailed transition plan and budget.~~

~~(2) The relocation specialist works with each allocated consumer/participant while in the NF to ensure that services, goods, and supports needed prior to the individual moving to the community are in place, and ensures that consumer/participants have the opportunity to educate their caregivers. The CoLTS MCO service coordinator is the single provider responsible for developing a comprehensive service plan for the individual when they are living in the community, its implementation and conducting service monitoring activities.~~

~~(3) Services are limited to 10 hours (or $500) per transition per person. In order to be eligible for this service, the person must have a nursing facility stay of at least 30 days prior to transition to the community. Services are also limited to no more than 180 days prior to transition to the community and no more than 60 days following transition to the community.~~] The CCW covers the following services for a specified and limited number of MAD waiver eligible recipients as a cost effective alternative to institutionalization in a NF.

A. Service coordination operates independently within a CoLTS MCO using recognized professional standards adopted by the MCO and approved by the MAD, based on the service coordinator's independent judgment to support the needs of the eligible recipient and is structurally linked to the other MCO systems, such as quality

assurance, recipient services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations. The MCO's service coordinator, who has experience in working with the elderly, individuals with disabilities, and others in need of long-term services, is responsible for ensuring that all applicable federal regulations and state rules involving service plan development are followed. Eligible service coordinator s include: registered nurses (RN), licensed practical nurses (LPN), social workers, or individuals with at least a bachelor's degree in counseling, special education or a closely related field. Service coordination activities include specialized service management that is performed by a service coordinator, in collaboration with the eligible recipient or his personal representatives as appropriate, which are person-centered, and includes, but are not limited to:

(1) identification of the eligible recipient's needs, including physical health services, behavioral health services, social services, and long-term support services; and development of the eligible recipient's ISP or treatment plan to address those needs:

(2) assistance to ensure timely and coordinated access to an array of providers and services;

(3) attention to addressing unique needs of an eligible recipient; and

(4) coordination with other services delivered in addition to those noted in the ISP, as necessary and appropriate.

B. **Private duty nursing services for adults:** Private duty nursing services must be provided under the order and the direction of the eligible recipient's PCP. Eligible practitioners are RNs or LPNs. Services rendered are within the nurse's practice board scope of licensure, developed in conjunction with the interdisciplinary team and the eligible recipient's service coordinator.

(1) Private duty nursing services must be provided in accordance with all applicable federal regulations and state rules and service standards. Depending on the age of the eligible recipient, services may be covered under MAD's early periodic screening, diagnostic and treatment (EPSDT) services.

(2) Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness or chronic disability. Services include the following:

(a) medication management, administration and teaching;

(b) aspiration precautions;

(c) feeding tube management;

(d) gastrostomy and jejunostomy care;

(e) skin care and wound care;

(f) weight management;

(g) urinary catheter management and bowel and bladder care;

(h) health education;

(i) health screening;

(j) infection control and environmental management for safety;

(k) nutrition management;

(l) oxygen management;

(m) seizure management and precautions;

(n) anxiety reduction;

(o) staff supervision; and

(p) behavior supports and self-care assistance.

C. **Respite services:** Respite services are provided to an eligible recipient that is unable to care for him/herself and are furnished on a short term basis due to the absence or need for relief of the unpaid primary caregiver normally providing the care.

(1) Respite services may consist of non-nursing services and/or non-private duty nursing services, based on the eligible recipient's needs.

(2) Respite services may be provided in the eligible recipient's home, the respite provider's home, or the community.

(3) Services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities, and allowing community integration opportunities.

(4) Respite services are limited to a maximum of 100 hours annually per ISP year.

D. **Skilled therapy services for adults:** Skilled maintenance therapy services for adults include PT, OT and SLT services. Children receive these services through the MAD EPSDT benefits.

(1) PT promotes gross and fine motor skills, facilitates independent functioning and works to prevent other progressive disabilities.

(a) Specific services may include:

(i) professional assessment(s), evaluations and monitoring for therapeutic purposes;

(ii) PT treatment interventions;

(iii) providing PT activity instruction to the eligible recipient;

(iv) usage of equipment and technologies while rendering a PT service to the eligible recipient;

(v) the designing, modifying or monitoring use of related environmental modifications;

(vi) the designing, modifying and monitoring the usage of related activities for use by the eligible recipient to support the ISP goals and objectives; and

(vii) with the approval of the eligible recipient, the therapist may consult and collaborate with other service providers and with the eligible recipient's caregivers.

(b) PT services must be provided in accordance with all applicable federal regulations and state and state and waiver rules.

(2) OT promotes fine motor skills, coordination, sensory integration, facilitates the use of adaptive equipment and assistive technology, facilitates independent functioning, and works to prevent other progressive disabilities.

(a) Specific services may include:

(i) teaching daily living skills instruction to the eligible recipient;

(ii) assisting the eligible recipient develop perceptual motor skills and sensory integrative functioning;

(iii) the designing, fabricating or modifying assistive technology or adaptive devices for use by the eligible recipient;

(iv) providing assistive technology services for use by the eligible recipient;

(v) the designing, fabricating or applying selected orthotic or prosthetic devices or selecting adaptive equipment for use by the eligible recipient;

(vi) utilizing the occupational therapist's specifically designed crafts and exercise to enhance the functioning of the eligible recipient;

(vii) providing OT activity training to the eligible recipient; and

(viii) with the approval of the eligible recipient, the therapist may consult and collaborate with other service providers and with the eligible recipient's caregivers.

(b) OT services must be provided in accordance with all applicable federal regulations, state and waiver rules.

(3) SLT preserves abilities for independent function in communication, facilitates oral motor and swallowing function, facilitates use of assistive technology, and works to prevent other progressive disabilities.

(a) Specific services may include:

(i) identifying and assessing the communicative or oropharyngeal disorders and delays in the development of communication skills of the eligible recipient;

(ii) working to prevent other communicative or oropharyngeal disorders and delays in the development of communication skills;

(iii) developing and implementing the eligible recipient's eating or swallowing plans, monitoring their effectiveness, and adjusting the plans as necessary;

(iv) utilizing the therapist's specifically designed equipment, tools, and exercises to enhance the functioning of the eligible recipient;

(v) the designing, fabricating or modifying assistive technology or adaptive devices for use by the eligible recipient;

(vi) providing assistive technology services for use by the eligible recipient;

(vii) adapting the environment to meet the needs of the eligible recipient;

(viii) providing SLT activity training to the eligible recipient; and

(ix) with the approval of the eligible recipient, the speech and language therapist may consult and collaborate with other service providers or with the eligible recipient's caregivers.

(b) SLT services must be provided in accordance with all federal regulations, state and waiver rules and service standards.

E. **Assisted living services:** Assisted living is a residential service that includes assistance with activities of daily living (ADL) services, companion services, medication management (to the extent required under state law and medication oversight as required by state law), 24-hour on-site response capability to meet scheduled or unpredictable needs of the eligible recipient, and to provide supervision, safety and security services to the

eligible recipient. Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision.

(1) Rates for room and board are excluded from the cost of services and are either billed separately by the provider or listed on an itemized statement that separates the costs of waiver services from the costs of room and board.

(2) Nursing and skilled therapy services are incidental, rather than integral to assisted living services. Nursing and skilled therapy services may be provided by third parties and must be coordinated with the assisted living facility.

(3) An assisted living facility must enter into an agreement with the eligible recipient that details all aspects of care to be provided including identified risk factors. The original agreement must be maintained in the eligible recipient's file and a copy must be provided by the assisted living facility to the eligible recipient's service coordinator.

(4) An assisted living facility must be provided by an assisted living facility that has been licensed and certified by DOH as an adult residential care facility, pursuant to 7.8.2 NMAC and all other applicable federal regulations, state and waiver rules.

F. **Adult day health services:** Adult day health services offer health and social services to assist an eligible recipient achieve optimal functioning and activates, motivates and rehabilitates the eligible recipient in all aspects of his or her physical and emotional well-being, based on the eligible recipient's specific needs.

(1) Services include:

(a) a variety of activities for an eligible recipient to promote personal growth and enhance the eligible recipient's self-esteem by providing opportunities to learn new skills and adaptive behaviors, improve capacity for independent functioning, or provide for group interaction in social and instructional programs and therapeutic activities; all activities must be supervised by program staff;

(b) supervision of self-administered medication ;

(c) the eligible recipient's involvement in the greater community;

(d) transportation of the eligible recipient to and from the adult day health program; and

(e) meals that do not constitute a "full nutritional regime" of three meals per day.

(2) Services are generally provided for two or more hours per day on a regularly scheduled basis, for one or more days per week, through a MAD enrolled assisted living facility. Services must be provided as set forth by DOH pursuant to 7.13.2 NMAC.

(3) The provider must assure the inside and outside of its facility meets federal, state and waiver health and safety requirements.

(4) Adult day health services include nursing services and skilled maintenance therapies (OT/PT/SPT) that must be provided in a private setting at the eligible recipient's adult day health facility. The nursing and skilled maintenance therapies do not have to be directly provided by the facility. If directly provided, the facility must meet all federal regulations, state and waiver rules for the provision of these services.

G. **Environmental modification services:** Environmental modifications services include the purchase and installation of equipment and making physical adaptations to an eligible recipient's residence that are necessary to ensure the health, welfare and safety of or enhance the level of independence for an eligible recipient.

(1) Adaptations include the following:

(a) installation of ramps and grab-bars;

(b) widening of doorways or hallways;

(c) installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;

(d) purchase and installation of lifts or elevators;

(e) modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing);

(f) turnaround space adaptations;

(g) specialized accessibility, safety adaptations and additions;

(h) installation of trapeze and mobility tracks for home ceilings;

(i) purchase and installation of automatic door openers or doorbells, voice-activated, light-activated, motion-activated and electronic devices;

(j) fire safety adaptations;

(k) purchase and installation of modified switches, outlets or environmental controls for home devices;

(l) purchase and installation of alarm and alert systems or signaling devices;

(m) air filtering devices;
(n) heating/cooling adaptations; and
(o) glass substitute for windows and doors.

(2) Service coordinators must consider alternative methods of meeting the eligible recipient's needs prior to listing environmental modifications on the ISP.

(3) Environmental modifications have a limit of up to $5,000 every five years.

(4) The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction or remodeling services, provide administrative and technical oversight of construction projects, provide consultation to the eligible recipient's family members as appropriate, waiver providers and contractors concerning environmental modification projects to the eligible recipient's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

(5) The environmental modification provider must submit the following information:
(a) an environmental modification evaluation;
(b) a service cost estimate including equipment, materials, supplies, labor, travel, per diem;
(c) a letter of acceptance of service cost estimate signed by the eligible recipient;
(d) a letter of permission from owner of property;
(e) a construction letter of understanding detailing the work proposed;
(f) photographs of the proposed modification; and
(g) documentation demonstrating compliance with the American with Disabilities Act Accessibility Guidelines (ADAAG), the uniform federal accessibility standards (UFAS), and the New Mexico state building code.

(6) After the completion of work, the environmental modification provider must submit the following to the MCO:
(a) a letter of approval of work completed, signed by the eligible recipient; and
(b) photographs of the completed modifications.

(7) Environmental modification services must be managed by professional staff available to provide technical assistance and oversight for environmental modification projects.

(8) Environmental modification services shall be provided in accordance with all applicable federal regulations, state and waiver rules.

H. **Emergency response services:** Emergency response services provide an electronic device that enables an eligible recipient to secure help in an emergency.

(1) Emergency response services include:
(a) testing and maintaining equipment;
(b) training to the eligible recipient, caregivers and first responders on use of the equipment;
(c) 24 hour monitoring for alarms;
(d) checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and

(2) The response center must be staffed by trained professionals.

(3) Emergency response service categories are emergency response and emergency response high need.

(4) An emergency response provider shall provide the eligible recipient with information regarding services rendered, limits of services and information regarding agency service contracts.

(5) The emergency response center will provide within 24 hours a report to the eligible recipient's CoLTS MCO all emergencies and changes in the eligible recipient's condition that may affect service delivery, complete and submit a quarterly report to the eligible recipient's MCO, of which the original report must be maintained in the eligible recipient's.

(6) Emergency response services shall be provided in accordance with all applicable federal regulations, state and waiver rules.

(7) The eligible recipient may also wear a portable "help" button to allow for mobility. The syste is connected to the eligible recipient's phone and programmed to signal a response center when a "help" button is activated. The response center reacts to the signal to ensure the eligible recipient's health and safety.

I. **Service coordination**: Service coordination operates independently within the [~~CoLTS~~] MCO using recognized professional standards adopted by the [~~CoLTS~~] MCO and approved by [~~the state~~] MAD, based on the service coordinator's independent judgment to support the needs of the [~~member~~] eligible recipient and is structurally linked to the other [~~CoLTS~~] MCO systems, such as quality assurance, [~~member~~] eligible recipient

services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations. The [~~CoLTS~~] MCO's service coordinator, who has experience in working with the elderly, individuals with disabilities, and others in need of long-term services, is responsible for ensuring that all applicable [~~policies and procedures~~] federal regulations, state and waiver rules and CCW services standards involving service plan development are followed. Service coordinators can be RNs, LPNs, social workers, or individuals with at least a bachelor's degree in counseling, special education or a closely related field. Service coordination activities include ~~s~~specialized service management that is performed by a service coordinator, in collaboration with the [~~member or the member's~~] eligible recipient or the eligible recipient's family or representatives as appropriate, which [~~is~~] are person-centered, and includes, but is not limited to:

(1) identification of the eligible recipient's needs, including physical health services, behavioral health services, social services, and long-term support services; and development of the eligible recipient's ISP or treatment plan to address those needs;

(2) assistance to ensure timely and coordinated access to an array of providers and services;

(3) attention to addressing unique needs of the eligible recipient; and

(4) coordination with other services delivered in addition to those noted in the ISP, as necessary and appropriate.

J. **Community transition goods and services:**

(1) Money follows the person (MFP) is a demonstration grant administered by CMS. During the grant period, grantee states use available grant funding to facilitate transitions from qualified institutions to qualified community settings. MFP transition goods and services are covered under CoLTS when New Mexico has been authorized by CMS as a grantee state. MFP participants must meet specific CMS criteria referenced in the CMS grant terms and conditions and the CMS approved state MFP operational protocol (OP). The definition for qualified eligible individuals, institutions and community settings are detailed in the OP.

(2) CCW Community transition goods and services: These are non-recurring set-up expenses for an MFP eligible recipient who is transitioning from an MFP qualified institution to an MFP qualified community setting as detailed in the MFP OP, or as approved by MAD or its designee. In order to be eligible for this service, the eligible recipient must have a NF stay at least equal to the criteria for participation in MFP federal grant terms and conditions or MAD or its designee for a minimum 30 calendar day NF stay prior to transition to his/her community. Allowable expenses are those necessary to enable the eligible recipient to establish a basic household that do not constitute room and board and may include:

(a) security deposits that are required to obtain a lease on an apartment or home where the eligible recipient will reside;

(b) essential household furnishings required to occupy the eligible recipient's residence including furniture, window coverings, food preparation items, and bed/bath linens;

(c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

(d) services necessary for the eligible recipient's health and safety such as pest eradication and one-time cleaning prior to occupancy;

(e) moving expenses related to the eligible recipient's change of residence;

(f) within 180 calendar days prior to the eligible recipient's occupancy of the new residence, necessary home environmental modifications to support the eligible recipient;

(g) specialized medical equipment and supplies not otherwise covered by MAD and purchased within 60 days of the scheduled transition;

(h) assistive technology and durable medical equipment not otherwise covered by MAD purchased within 60 calendar days of the scheduled transition;

(i) nutrition support services such as short-term nutritional counseling and education in food preparation skills;

(j) non-medical transportation;

(k) non-medical transportation supports such as vehicle modification;

(l) family services to support or educate the informal support network; and

(m) the purchase and related costs of service dogs up to service limits.

(3) Community transition goods and services are furnished only to the extent that the goods or services:

(a) are reasonable and necessary as determined through the service plan development process;

(b) are clearly identified in the service plan;

(c) cannot be obtained from other sources;

(d) are not prohibited by federal regulations and state rules and service standards;

(e) are not experimental in nature; and

(f) the eligible recipient has no other access to these services.

(4) Community transition goods and services do not include monthly rental or mortgage expense, food, regular utility charges, or household appliances or items that are intended for purely diversion/recreation purposes.

(5) CCW Community transition goods and services are limited to $3,500.00 per person every five years or as defined in the MFP OP, whichever is greater. In order to be eligible for this service, the eligible recipient must have a NF stay at least equal to the criteria for participation in the MFP federal demonstration grant terms and conditions, or as approved by MAD or its designee for a minimum of a 30-calendar day NF stay prior to transitioning to his/her community. The individual's eligibility status as an eligible recipient must be verified prior to discharge from the NF.CCW transition goods and services are limited to an eligible recipient who has established Medicaid eligibility prior to discharge from the NF or qualifying facility as set forth in the OP.

K. C**ommunity relocation specialist services:** The CoLTS MCO is responsible for the designation and the oversight of the community transition relocation specialist (CTRS). CTRS services are specialized services, provided while the eligible recipient is in a NF and at a minimum, during the first 60 calendar days of the transition period**.**

(1) The CTRS must assess the eligible recipient's needs, complete a service plan, assist the eligible recipient arrange for and procure needed resources for the move from the NF to the community, and monitor transition service delivery. The CTRS provides the eligible recipient information on MAD's home and community-based service options, its transition process, and other relevant issues. The CTRS works with the eligible recipient, his support network when applicable, and his MCO service coordinator to develop a person-centered, community-based transition plan. This plan includes a detailed transition plan and budget, and is as part of the eligible recipient's ISP.

(2) The CTRS and the eligible recipient in the NF work together to ensure that the needed services, goods and supports are in place prior to the eligible recipient's move. The CTRS is to ensure the caregiver has specific education to provide the necessary services to the eligible recipient. The CTRS works with the MCO service coordinator to ensure transition services are included in the comprehensive ISP and are implemented and monitored by the service coordinator.

(3) The CTRS must provide services for an eligible recipient:

(a) a minimum of 60 calendar days if institutionalized for 6 or more months; or

(b) a minimum of 14 calendar days if institutionalized for less than 6 months;

(c) services are limited to 10 hours or up to $500 per transition per eligible recipient;

(d) services are limited to no more than 180 calendar days prior to transition from the NF to the community; and

(e) services are limited to no more than 60 calendar days following transition from the NF to the community.

[8.307.18.13 NMAC - N, 12-15-10; A, 7-1-12]

8.307.18.14 NON-COVERED SERVICES: [~~Only the services listed as covered waiver services in these regulations are provided under the CCW program. CCW eligible recipients qualify for full state plan medicaid benefits. Additional services may be accessed through medicaid state plan services. See 8.301.3 NMAC, *General Noncovered Services* for an overview of non-covered services. Medicaid does not cover room and board as waiver service or ancillary services.~~] [~~Only the services listed as covered waiver services in these regulations are provided under the CCW program. CCW eligible recipients qualify for full state plan medicaid benefits. Additional services may be accessed through medicaid state plan services.~~] A CCW eligible recipient receives full state plan medicaid benefits in addition to the CCW services listed as covered waiver services in this rule. MAD does not cover room and board as a waiver service or as ancillary services. See 8.301.3 NMAC, *General Noncovered Services* for an overview of non-covered services.

[8.307.18.14 NMAC - N, 12-15-10; A, 7-1-12]

8.307.18.15 INDIVIDUALIZED SERVICE PLAN (ISP): An ISP must be developed by an interdisciplinary team of professionals in collaboration with the eligible recipient and others involved in the eligible recipient's care. The ISP must be in accordance with the CCW service standards.

A. The interdisciplinary team must review the ISP at least every six months or more often if indicated.

B. The individualized services plan must contain the following information:

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

(2) a description of the functional level of the eligible recipient;

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

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

(5) a statement and rationale of the ISP for achieving [~~these~~] the eligible recipient's intermediate and long-range goals, including provision for review and modification of the eligible recipient's plan; [~~and~~]

(6) the specification of responsibilities for areas of care, description of needs, and orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the eligible recipient; and

(7) a person-centered service plan for community-based transition benefits, services and budget for a recipient eligible for such benefits and services.

[8.307.18.15 NMAC - N, 12-15-10; A, 7-1-12]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 7 BENEFIT PACKAGE

8.307.7.1 ISSUING AGENCY: Human Services Department (HSD)
[8.307.7.1 NMAC - N, 8-1-08; A, 7-1-12]

8.307.7.6 OBJECTIVE: [~~The objective of these rules is to provide policies instructions for the service portion of the New Mexico medicaid coordination of long-term services program.~~] The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.307.7.6 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

8.307.7.8 MISSION STATEMENT: [~~The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.~~] To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.307.7.8 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

8.307.7.9 BENEFIT PACKAGE: [~~This part defines the medicaid benefit package for which the coordination of long-term services managed care organization (CoLTS MCO) shall be paid fixed per-member per-month payment rates. The CoLTS MCO shall cover these services. The CoLTS MCO shall not delete benefits from the medicaid-defined benefit package. The CoLTS MCO must utilize service providers licensed in accordance with state and federal requirements to deliver services.~~] The medical assistance division (MAD) benefit package for the coordination of long-term services managed care organization (MCO) and the statewide behavioral health single entity (SE) shall each be paid fixed per-member-per-month payment rates. The MCO and SE shall cover these services. The MCO is responsible for covering the physical health services except as otherwise directed in this rule or by contract. The SE is responsible for covering the behavioral health services. The MCO and the SE shall not delete benefits from the MAD-defined benefit package. The MCO and SE must utilize service providers licensed in accordance with state and federal requirements to deliver services. MAD pays for medically necessary health care services for eligible recipients. For an eligible recipient also enrolled in medicare, the medicare replacement plan becomes the primary payer for services covered by medicare.
[8.307.7.9 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

8.307.7.10 MEDICAL ASSISTANCE DIVISION PROGRAM POLICY MANUAL: [~~The medical assistance division program policy manual contains a detailed explanation of the services covered by [medicaid MAD, limitations to and exclusions of covered services, services that are not covered by medicaid. The manual is the official source of information on covered and noncovered services. The CoLTS MCO shall determine its own utilization management (UM) protocols that are based on reasonable medical evidence and are not bound by those found in the medicaid program manual. The human services department (HSD) or its designee must review and approve the CoLTS MCO's UM protocols.~~] Health care to New Mexico eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD through a CoLTS managed care organization (MCO). MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.
[8.307.7.10 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

8.307.7.11 [~~SERVICES INCLUDED IN THE [COORDINATION OF LONG-TERM SERVICES] PROGRAM BENEFIT PACKAGE:~~ ~~The CoLTS MCO must provide a comprehensive, coordinated and fully integrated system of health care, long-term services, and social and community services to its members. The~~

following are state plan services provided under the authority of the 1915(b) waiver and are available to all CoLTS members. The CoLTS 1915 (c) waiver provides home and community-based services to eligible recipients who are disabled or elderly, as an alternative to institutionalization. 8.307.18 NMAC describes CoLTS 1915 (c) waiver eligible recipients, eligible providers, covered waiver services, non-covered services, utilization review and provider reimbursement.

A. **Ambulatory surgical services (CoLTS MCO):** The benefit package includes surgical services rendered in an ambulatory surgical center setting, as set forth in 8.324.10 NMAC, *Ambulatory Surgical Center Services*.

B. **Anesthesia services (CoLTS MCO):** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures, as set forth in 8.310.5 NMAC, *Anesthesia Services*.

C. **Audiology services (CoLTS MCO):** The benefit package includes audiology services, as set forth in 8.324.6 NMAC, *Hearing Aids and Related Evaluation*.

D. **Case management services:** The benefit package includes the following case management services:

(1) **case management services for pregnant women and their infants (CoLTS MCO):** case management services provided to pregnant women up to 60 days following the end of the month of the delivery, as set forth in 8.326.3 NMAC, *Case Managements Services for Pregnant Women and Their Infants*;

(2) **case management services for traumatically brain injured adults (CoLTS MCO):** case management services provided to adult members (21 years of age or older) who are traumatically brain injured, as set forth in 8.326.6 NMAC, *Case Management Services for Traumatically Brain Injured Adults*;

(3) **case management services for children up to the age of three (CoLTS MCO):** case management services provided to children up to the age of three who are medically at risk due to family conditions and not developmentally delayed, as detailed in 8.326.6 NMAC, *Case Management Services for Children Up to Age Three*;

(4) **case management services for the medically at risk (CoLTS MCO):** case management services for individuals who are under 21 and are medically at risk for physical or behavioral health conditions, as set forth in 8.320.5 NMAC, *EPSDT Case Management*; "medically at risk" is defined as those individuals who have a diagnosed physical or behavioral health condition that has a high probability of impairing their cognitive, emotional, neurological, social, behavioral, or physical development;

(5) **case management services for adults with developmental disabilities (CoLTS MCO):** case management services provided to adult members (21 years of age or older) who are developmentally disabled, as detailed in 8.326.2 NMAC, *Case Management Services for Adults with Developmental Disabilities*; and

(6) **case management services for the chronically mentally ill (SE only):** case management services provided to adults who are 18 years of age or older and who are chronically mentally ill, as detailed in 8.326.4 NMAC, *Case Management Services for the Chronically Mentally Ill*.

E. **Dental services (CoLTS MCO):** The benefit package includes dental services, as set forth in 8.310.7 NMAC, *Dental Services*.

F. **Diagnostic imaging and therapeutic radiology services (CoLTS MCO):** The benefit package includes medically necessary diagnostic imaging and radiology services, as set forth in 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services*. Radiology costs shall be the responsibility of the SE when they are provided within, and billed by, a freestanding psychiatric hospital, a PPS exempt unit of a general acute hospital or UNM psychiatric emergency room. In the event that a psychiatrist orders radiology services but completes those tests in his/her office/facility and bills for it, the SE shall be responsible for payment. Radiology costs shall be the responsibility of the CoLTS MCO when a BH provider orders radiology services that are performed by an outside, independent radiology facility, including those radiology services provided for persons within a freestanding psychiatric hospital, a psychiatric unit, a psychiatric unit within a general hospital or UNM psychiatric ER. All other diagnostic imaging and therapeutic radiology services shall be the responsibility of the CoLTS MCO.

G. **Dialysis services (CoLTS MCO):** The benefit package includes medically necessary dialysis services, as set forth in 8.325.2 NMAC, *Dialysis Services*. Dialysis providers shall assist members in applying for and pursuing final medicare eligibility determination.

H. **Durable medical equipment and medical supplies (CoLTS MCO):** The benefit package includes the purchase, delivery, maintenance, and repair of equipment, oxygen, and oxygen administration equipment, nutritional products, disposable diapers, and disposable supplies essential for the use of the equipment, as set forth in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies.*

I. **Emergency services (CoLTS MCO):** The benefit package includes emergency and post-stabilization care services. Emergency services are inpatient and outpatient services that are furnished by a qualified service provider and that are needed to evaluate or stabilize an emergency condition. An emergency condition shall meet the definition of emergency, as set forth in 8.307.1.7 NMAC, *definitions*. The CoLTS MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Emergency services shall be provided in accordance with Subsection F of 8.307.7.11 NMAC, *diagnostic imaging and therapeutic radiology services*. Post-stabilization care services are covered services related to an emergency condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition, such that within reasonable medical probability, no material deterioration of the member's condition is likely to result from or occur during discharge of the member or transfer of the member to another facility.

J. **EPSDT services (CoLTS MCO):** The benefit package includes the delivery of the federally mandated early and periodic screening, diagnosis and treatment (EPSDT) services set forth in 8.320.2 NMAC, *EPSDT Services*, and the following:

(1) **EPSDT private duty nursing (CoLTS MCO):** Private duty nursing for the EPSDT population, as set forth in 8.323.4 NMAC, *EPSDT Private Duty Nursing Services*. The services shall be delivered in the member's home or the school setting.

(2) **EPSDT personal care (CoLTS MCO):** Medically necessary personal care services furnished to members under 21 years of age as part of EPSDT, as set forth in 8.323.2 NMAC, *EPSDT Personal Care Services.*

(3) **Tot-to-teen health checks (CoLTS MCO):** The CoLTS MCO shall adhere to the periodicity schedule and ensure that eligible members receive EPSDT screens (tot-to-teen health checks), including:

(a) education of and outreach to members regarding the importance of health checks;

(b) development of a proactive approach to ensure that the services are received by members;

(c) facilitation of appropriate coordination with school-based providers;

(d) development of a systematic communication process with the CoLTS MCO's network providers regarding screens and treatment coordination for members;

(e) process to document, measure and ensure compliance with the periodicity schedule; and

(f) development of a proactive process to ensure the appropriate follow-up of evaluations, referrals or treatment, especially early intervention for mental health conditions, vision and hearing screens, and current immunizations.

K. **Health education and preventive services:** The CoLTS MCO shall:

(1) provide a continuous program of health education without cost to its members; such a program includes publications, media, presentations, and classroom instruction;

(2) provide programs of wellness education;

(3) make preventive service available to members; the CoLTS MCO shall periodically remind and encourage members to use benefits, including physical examinations, that are available and designed to prevent illness;

(4) initiate targeted prevention initiatives for members with acute and chronic disease; and

(5) develop policies and procedures that encourage the proactive performance of home safety evaluations for all at-risk members transitioning from institutions to community settings.

L. **Home health services (CoLTS MCO):** The benefit package includes home health services, as set forth in 8.325.9 NMAC, *Home Health Services*.

M. **Hospice services (CoLTS MCO/SE):** The benefit package includes hospice services, as set forth in 8.325.4 NMAC, *Hospice Care Services.*

N. **Hospital outpatient services (CoLTS MCO/SE):** The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative, or palliative medical or behavioral health services, as set forth in 8.311.2 NMAC, *Outpatient Covered Services*.

O. **Inpatient hospital services (CoLTS MCO/SE):** The benefit package includes hospital inpatient acute care, procedures and services, as set forth in 8.311.2 NMAC, *Hospital Services*. The CoLTS MCO/SE shall comply with the maternity length of stay as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both the mother and newborn child.

P. **Laboratory services (CoLTS MCO/SE):** The benefit package includes all laboratory services provided according to the applicable provisions of the Clinical Laboratory Improvement Act (CLIA), as set forth in 8.324.2 NMAC, *Laboratory Services*. Laboratory costs shall be the responsibility of the SE when they are provided

within, and billed by, a freestanding psychiatric hospital, a PPS exempt unit of a general acute hospital or UNM psychiatric emergency room. In the event that a psychiatrist orders lab work but completes that lab work in his/her office/facility and bills for it, the SE shall be responsible for payment. Lab costs shall be the responsibility of the CoLTS MCO when a BH provider orders lab work that is performed by an outside, independent laboratory, including those lab services provided for persons within a freestanding psychiatric hospital, a psychiatric unit, a psychiatric unit within a general hospital or UNM psychiatric ER. All other covered laboratory services shall be the responsibility of the CoLTS MCO.

Q. **Nursing facility services (CoLTS MCO):** The benefit package includes services provided in nursing facilities or hospital swing beds to members expected to reside in those facilities, as set forth in MAD 731, *Nursing Facilities*, and MAD 723, *Swing Bed Hospital Services*.

R. **Nutritional services (CoLTS MCO):** The benefit package includes nutritional services furnished to pregnant women and children, as set forth in 8.324.9 NMAC, *Nutritional Services*.

S. **Personal care option (PCO) services (CoLTS MCO):** The benefit package includes PCO services, as set forth in 8.315.4 NMAC, *Personal Care Option Services*.

T. **Pharmacy services (CoLTS MCO/SE):** The benefit package includes all pharmacy and related services, as set forth in 8.324.4 NMAC, *Pharmacy Services*. The CoLTS MCO/SE shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal medicaid laws. The CoLTS MCO/SE shall use a single medicaid preferred drug list (PDL). The CoLTS MCO/SE shall cover brand name drugs and drug items not generally on the CoLTS MCO/SE formulary or PDL when determined to be medically necessary by the CoLTS MCO/SE or through a fair hearing process. The CoLTS MCO/SE shall include on their formulary or PDL all multi-source generic drug items with the exception of items used for cosmetic purposes, items consisting of more than one therapeutic ingredient, anti-obesity items, items which are not medically necessary, and cough, cold and allergy medications. The CoLTS MCO/SE shall reimburse family planning clinics, school based health clinics, and DOH public health clinics for oral contraceptive agents and Plan B when dispensed to members and billed using HCPC codes and CMS 1500 claim forms. The CoLTS MCO shall coordinate as necessary with the SE, and the SE shall coordinate with the CoLTS MCO and the member's PCP when administering pharmacy services. The SE shall be responsible for payment of all drug items prescribed by a behavioral health provider, such as psychiatrists, psychologists certified to prescribe, psychiatric clinical nurse specialists, psychiatric nurse practitioners, and any other prescribing practitioner contracted with the SE. The CoLTS MCO/SE shall ensure that Native American members accessing the pharmacy benefit at IHS or tribal 638 facilities will be exempt from the CoLTS MCO's/SE's preferred drug list.

(1) The CoLTS MCO's preferred drug list (PDL) shall use the following guidelines:

(a) there must be at least one representing drug for each of the categories in the first data bank blue book;

(b) generic substitution shall be based on "AB" rating or clinical need;

(c) for a multiple source, brand name product within a therapeutic class, the CoLTS MCO may select a representative drug;

(d) the PDL shall follow the centers for medicare and medicaid services (CMS) special guidelines relating to drugs used to treat HIV infection;

(e) the PDL shall include coverage of certain over the counter (OTC) drugs by a licensed practitioner; and

(f) the CoLTS MCO shall implement an appeals process for service providers who believe that an exception to the PDL should be made for an individual member.

(2) The CoLTS MCO shall use a PDL developed with consideration of the clinical efficiency, safety and cost effectiveness of drug items, and shall provide medically appropriate drug therapies for members. Drug items not on the PDL must be considered for coverage on a prior authorization basis. Atypical antipsychotic medications must be available in the same manner as conventional antipsychotic medications for the treatment of severe mental illness, including schizophrenia, clinical depression, bipolar disorder, anxiety-panic disorder, and obsessive-compulsive disorder. Upon development, the CoLTS MCO will be required to deliver its pharmacy benefit package using a single medicaid PDL.

(3) The CoLTS MCO shall coordinate as necessary with the single statewide entity (SE) when administering pharmacy services, to ensure that member and service provider questions are directed appropriately. The CoLTS MCO shall edit pharmacy claims to ensure that any authorizations given and claims paid are within the scope of the responsibility of the CoLTS MCO or the CoLTS MCO's pharmacy subcontractor, and shall inform members or providers when the claims fall under the scope of responsibility of the SE. Such determinations will be based primarily on the prescriber and other criteria as provided by the state.

(4) The CoLTS MCO shall maintain written policies and procedures governing its drug utilization review (DUR) program, in compliance with federal and state law and regulations.

(5) The CoLTS MCO shall coordinate the delivery of the pharmacy benefit when medicare part D is the primary coverage.

(6) The CoLTS MCO shall ensure that any member who takes nine or more different prescription medications has their medications reviewed by a medical clinician for appropriateness and the identification and correction of potentially harmful practices, and shall document this review in the member's chart at least every six months.

U. **Physical health services (CoLTS MCO):** The benefit package includes primary (including those provided in school-based settings) and specialty physical health services provided by a licensed practitioner and performed within their scope of practice, as defined by state law and set forth in 8.310.2.9 NMAC, *medical services providers*; 8.310.9 NMAC, *Midwife Services*, including attending out-of-hospital births and other related birthing services performed by certified nurse-midwives or direct-entry midwives licensed by the state of New Mexico, who are either: (1) validly contracted with and fully credentialed by the CoLTS MCO, or (2) validly contracted with the HSD medical assistance division and participate in HSD's birthing options program; 8.310.11 NMAC, *Podiatry Services*; 8.310.3 NMAC, *Rural Health Clinic Services*; and 8.310.4 NMAC, *Federally Qualified Health Center Services*.

V. **Pregnancy termination services (CoLTS MCO):** The benefit package includes coverage of pregnancy terminations for rape, incest and endangerment to the life of the mother, as allowed in accordance with 42 CFR Section 441.202. A certification from the network provider must be provided prior to payment. Medically necessary pregnancy terminations that do not meet the requirements of 42 CFR Section 441.202 are excluded from the capitation payment made to the CoLTS MCO, and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC, *Pregnancy Termination Procedures*.

W. **Preventive health services (CoLTS MCO):** The benefit package includes preventive health services, including:

(1) **Immunizations:** The CoLTS MCO shall ensure that, within six months of enrollment, members are current with immunizations according to the type and schedule provided by the most recent version of the recommendations of the advisory committee on immunization practices (ACIP) of the centers for disease control and prevention, public health service, U.S. department of health and human services. This may be done by providing the necessary immunizations or by verifying the immunization history by a method deemed acceptable by the ACIP. "Current" is defined as no more than four months overdue.

(2) **Screens:** The CoLTS MCO shall ensure that, to the extent possible, asymptomatic members receive and are current for at least the following screening services within six months of enrollment or within six months of a change in the standard. The CoLTS MCO shall require its network providers to perform the appropriate interventions based on the results of the screens. "Current" is defined as no more than four months overdue. The CoLTS MCO shall ensure that clinically appropriate follow-up or intervention is performed when indicated by the screening results.

(a) **Screening for breast cancer:** Female members age 50-69 who are not at high risk for breast cancer shall be screened annually with mammography and a clinical breast examination. Female members at high risk for developing breast cancer shall be screened as often as clinically indicated.

(b) **Screening for cervical cancer:** Female members with a cervix shall receive papanicolaou (PAP) testing starting at the onset of sexual activity, but at least by 18 years of age, and every three years thereafter until reaching 65 years of age, if prior testing has been consistently normal and the member has been confirmed to be not at high risk. If the member is at high risk, the testing frequency shall be at least annual.

(c) **Screening for colorectal cancer:** Members age 50 and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy at a periodicity determined by the CoLTS MCO.

(d) **Blood pressure measurement:** Members of all ages shall receive a blood pressure measurement as medically indicated.

(e) **Serum cholesterol measurement:** Male members age 35-65 and female members age 45-65 who are at normal risk for coronary heart disease shall receive serum cholesterol measurement every five years. Those members with multiple risk factors shall also receive HDL-C measurement.

(f) **Screening for obesity:** All members shall receive annual body weight and height measurements to be used in conjunction with a calculation of the body mass index or referenced to a table of recommended weights.

(g) **Screening for elevated lead levels:** Members age nine to 15 months (ideally 12 months old) shall receive a blood lead measurement at least once.

(h) **Screening for diabetes:** Members shall receive a fasting or two-hour post-prandial serum glucose measurement at least once.

(i) **Screening for tuberculosis:** Members shall receive a tuberculin skin test based on the level of individual risk for development of the infection.

(j) **Screening for rubella:** Female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology at their first clinical encounter in an office setting.

(k) **Screening for visual impairment:** Members three to four years of age shall be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test.

(l) **Screening for hearing impairment:** Members age 50 and older shall be routinely screened for hearing impairment by questioning them about their hearing.

(m) **Screening for problem drinking and substance abuse:** Adolescent and adult members shall be screened at least once by a careful history of alcohol use or the use of a standardized screening questionnaire, such as the alcohol use disorders identification test (AUDIT) or the four-question CAGE instrument and the substance abuse screening and severity inventory (SASSI). The frequency of screening shall be determined by the results of the first screen and other clinical indications. Members shall be referred to the SE as warranted.

(n) **Prenatal screening:** Pregnant members shall be screened for preeclampsia, D (Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, and vaginal and rectal group B streptococcal infection; and counseled and offered testing for HIV.

(o) **Newborn screening:** At a minimum, newborn members shall be screened for phenylketonuria, congenital hypothyroidism, galactosemia, and any other congenital disease or condition specified in accordance with department of health regulations, specifically 7 NMAC 30.6, *Newborn genetic screening program*.

(p) **Behavioral health screening:** During an encounter with a primary care provider (PCP), a behavioral health screen shall occur.

(3) **Tot-to-teen health checks:** The CoLTS MCO shall operate a tot-to-teen health check program for members up to 21 years of age to ensure the delivery of federally mandated EPSDT services. Within six months of enrollment, the CoLTS MCO shall endeavor to ensure that eligible members are current according to the screening schedule for EPSDT services.

(4) **Counseling services:** The CoLTS MCO shall provide to applicable asymptomatic members counseling on the following unless member refusal is documented: to prevent tobacco use; to promote physical activity; to promote a healthy diet; to prevent osteoporosis and heart disease in menopausal female members; to prevent motor vehicle injuries; to prevent household and recreational injuries; to prevent dental and periodontal disease; to prevent HIV infection and other sexually transmitted diseases; and to prevent unintended pregnancies.

(5) **Health advisor hotline:** The CoLTS MCO shall provide a toll-free health advisor hotline, which shall provide at least the following:

(a) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic conditions;

(b) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and

(c) pre-diagnostic and post-treatment service decision assistance based on symptoms.

(6) **Family planning policy (CoLTS MCO):** The CoLTS MCO shall have a written family planning policy to ensure that members of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to the following: methods of contraception; evaluation and treatment of infertility; risk reduction practices for HIV and other sexually transmitted diseases; options for pregnant members who do not wish to keep a child; and options for pregnant members who may wish to terminate the pregnancy.

(7) **Prenatal care program (CoLTS MCO):** The CoLTS MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal services consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(a) educational outreach to all members of childbearing ages;

(b) prompt and easy access to obstetrical services, including providing an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(c) risk assessment of all pregnant members to identify high risk cases for special management;

(d) counseling that strongly advises voluntary testing for HIV;

(e) case management services to address the special needs of members who have a high risk pregnancy, especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;

(f) screening for determination of need of a post-partum home visit; and

(g) coordination with other services in support of good prenatal care, including transportation and other community services and referral to an agency that dispenses free or reduced price baby car seats.

X. **Prosthetics and orthotics (CoLTS MCO):** The benefit package includes prosthetic and orthotic services, as set forth in 8.324.8 NMAC, *Prosthetics and Orthotics*.

Y. **Rehabilitation services (CoLTS MCO):** The benefit package includes inpatient and outpatient hospital and outpatient physical, occupational and speech therapy services, as set forth in 8.325.8 NMAC, *Rehabilitation Services*; and licensed speech and language pathology services furnished under the EPSDT program, as set forth in 8.323.5 NMAC, *Licensed Speech and Language Pathologists*.

Z. **Reproductive health services (CoLTS MCO):** The benefit package includes reproductive health services, as set forth in 8.325.3 NMAC, *Reproductive Health Services*. The CoLTS MCO shall provide members with sufficient information to allow them to make informed choices, including: the types of family planning services available; the member's right to access these services in a timely and confidential manner; and the freedom to choose a qualified family planning provider. A female member shall have the right to self-refer to a women's health specialist within the CoLTS MCO's provider network for covered services necessary to provide women's routine and preventive health care services. This right of self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist.

AA. **School-based services (CoLTS MCO/SE):** The benefit package includes services provided in schools, excluding those specified in the individualized education plan (IEP) or individualized family service plan (IFSP), as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*.

BB. **Service coordination:** The benefit package includes service coordination that is person-centered and intended to support members in pursuing their desired life outcomes by assisting them in accessing support and services necessary to achieve the quality of life that they desire in a safe and healthy environment. Service coordination assists members in gaining access to needed coordination of long-term services program waiver services; medicaid state plan services; and medical, social, educational and other services, regardless of the funding source for the services to which access is needed.

CC. **Telehealth services (CoLTS MCO/SE):** The benefit package includes telehealth services as set forth in 8.310.13 NMMAC, *Telehealth Services.*

DD. **Transplant services (CoLTS MCO):** The following transplants are covered in the benefit package as long as the indications are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants, and corneal transplants, as set forth in 8.325.5 NMAC, *Transplant Services*. Also see 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies* for guidance on determining if transplants are experimental or investigational.

EE. **Transportation services (CoLTS MCO):** The benefit package includes transportation services such as ground ambulance, air ambulance, taxicab or handivan, commercial bus, commercial air, meal, and lodging services, as indicated for medically necessary physical and behavioral health services, as set forth in 8.324.7 NMAC *Transportation Services*. In addition, the CoLTS MCO must abide by New Mexico law and regulations, specifically NMSA 1978 Section 65-2-97(F), stating that rates paid by the CoLTS MCO to transportation providers are not subject to and are exempt from New Mexico public regulation commission approved tariffs. The CoLTS MCO is also required to coordinate, manage and be financially responsible for the delivery of the transportation benefit to members receiving physical health services or behavioral health services. The CoLTS MCO shall coordinate with the SE as necessary to perform this function. Such coordination shall include:

(1) receiving information from and providing information to the SE regarding members and service providers;

(2) meeting with the SE to resolve provider and member issues to improve services, communication and coordination;

(3) contacting the SE, as necessary, to provide quality transportation services; and

(4) maintaining and distributing statistical information and data as may be required.

FF. **Vision services (CoLTS MCO):** The benefit package includes vision services, as set forth in 8.310.6 NMAC, *Vision Care Services*.

GG. The following are services provided under the 1915 (c) waiver to CoLTS members who meet specific criteria.

(1) **Adult day health services (CoLTS MCO):** The benefit package includes adult day health

services, which 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, community based facility that offers health and social services to assist eligible members in achieving optimal functioning. Private duty nursing services and skilled maintenance therapies (physical, occupational and speech therapies) may be provided in conjunction with adult day health services by the adult day health service provider or by another service provider. Private duty nursing services and skilled maintenance therapies must be provided in a private setting at the facility.

(2) **Assisted living services (CoLTS MCO):** The benefit package includes assisted living services, which are residential services that include personal support services, companion services, and assistance with medication administration, as set forth in department of health regulations 7.8.2 NMAC, *Residential Health Facilities.*

(3) **Community transition goods and services, and community relocation specialist services (CoLTS MCO):** The benefit package includes community transition and relocation specialist services designed to move individuals, where appropriate, from an institutional setting to home and community based programs, as detailed in the coordination of long term services contract.

(4) **Emergency response services (CoLTS MCO):** The benefit package includes emergency response services, including the provision of an electronic device that enables members to secure help in an emergency. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's telephone and programmed to signal a response center when the "help" button is activated. The response center must be staffed by trained professionals. Emergency response services include testing and maintaining equipment; training members, caregivers and first responders on the use of the equipment; 24 hour monitoring for alarms; checking systems monthly, or more frequently, if warranted by electrical outages, severe weather or other conditions; and reporting member emergencies and changes in the member's condition that may affect service delivery. Emergency categories consist of emergency response and emergency response high need.

(5) **Environmental modifications (CoLTS MCO):** The benefit package includes environmental modifications, including the purchase or installation of equipment or the making of physical adaptations to a member's residence that are necessary to ensure the health, welfare and safety of the member, or to enhance the member's level of independence.

(a) Adaptations include: installing ramps and grab bars; widening doorways/hallways; installing specialized electric and plumbing systems to accommodate medical equipment and supplies; installing lifts or elevators; modifying bathroom facilities; adapting turnaround spaces; making specialized accessibility and safety adaptations; making household additions; installing trapeze and mobility tracks for home ceilings; installing automatic door openers and doorbells; installing voice, light or motion activated electronic devices; making fire safety adaptations; installing air filtering devices; making heating/cooling adaptations; installing glass substitutes for windows and doors; installing modified switches, outlets or environmental controls for home devices; and installing alarm and alert systems or signaling devices.

(b) All environmental modifications shall be provided in accordance with applicable federal and state laws and regulations, and local building codes. The CoLTS MCO must ensure that proper design criteria is used in planning and designing the adaptation; provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services; provide administrative and technical oversight of construction projects; provide consultants to family members, waiver providers, and contractors concerning environmental modification projects; and inspect the final environmental modification project to ensure that the adaptations meet the approved plan.

(6) **Private duty nursing services (CoLTS MCO):** The benefit package includes private duty nursing services, including activities, procedures and treatment for a physical condition, physical illness or chronic disability. Services include: 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; health screening; infection control; environment management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self care assistance.

(7) **Respite services (CoLTS MCO):** The benefit package includes respite services provided to members who are unable to care for themselves. Respite services are provided on a short term basis because of the absence or need for relief of those persons normally providing the services. Respite services may be provided in a member's home or in the community. Services include: assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation, and eating); enhancing self-help skills; providing opportunities for leisure, play and other recreational activities; and allowing community integration.]

SERVICES INCLUDED IN THE COLTS 1915 (B) WAIVER PROGRAM BENEFIT PACKAGE:

A. Physical and behavioral health benefits that are available to full-benefit eligible recipient in the MAD fee-for-service (FFS) are covered for an eligible recipient enrolled in the CoLTS program. Refer to the benefit descriptions found in the MAD general benefit descriptions 8.301 NMAC; the medical and institutional services and providers found in NMAC sections 8.310 through 8.312, 8.314, 8.315, and 8.324 through 8.326, and as specified in the contract and the New Mexico state plan. Additional services are available under the CoLTS 1915 (b) waiver program to an eligible recipient when medically necessary. Refer to benefits descriptions found in NMAC 8.307, and as specified in the contract and CoLTS (b) waiver.

B. Physical and behavioral health benefits that are available to an early and periodic screening, diagnostic and treatment (EPSDT) eligible recipient in the MAD fee-for-service (FFS) are covered for an eligible recipient enrolled in the CoLTS program. Refer to the benefit descriptions found in the NMAC sections 8.320 through 8.323, and as specified in the MCO contract and the New Mexico state plan. The EPSDT benefit package includes the delivery of the federally mandated EPSDT services.

(1) **Tot-to-teen health checks** The MCO shall adhere to the periodicity schedule and ensure that an eligible recipient receives EPSDT screens (tot-to-teen health checks), including:

(a) education of and outreach to an eligible recipient regarding the importance of health checks;

(b) development of a proactive approach to ensure that the services are received by [~~members~~] an eligible recipient;

(c) facilitation of appropriate coordination with school-based providers;

(d) development of a systematic communication process with the MCO's network providers regarding screens and treatment coordination for an eligible recipient's condition;

(e) a process to document, measure and ensure compliance with the periodicity schedule; and

(f) development of a proactive process to ensure the appropriate follow-up of evaluations, referrals or treatment, especially early intervention for mental health conditions, vision and hearing screens, and current immunizations.

C. **Case management services:** The benefit package includes the following case management services:

(1) **case management services for eligible recipient pregnant women and their infants :** case management services provided to eligible recipient pregnant women up to 60 calendar days following the end of the month of the delivery, as set forth in 8.326.3 NMAC, *Case Managements Services for Pregnant Women and Their Infants*;

(2) **case management services for eligible recipient traumatically brain injured adults:** case management services provided to adult members (21 years of age or older) who are traumatically brain injured, as set forth in 8.326.6 NMAC, *Case Management Services for Traumatically Brain Injured Adults*;

(3) **case management services for eligible recipient children up to the age of three:** case management services provided to eligible recipient children up to the age of three who are medically at risk due to family conditions and not developmentally delayed, as detailed in 8.326.6 NMAC, *Case Management Services for Children Up to Age Three*;

(4) **case management services for the medically at risk :** case management services for eligible recipients who are under 21 and are medically at risk for physical or behavioral health conditions, as set forth in 8.320.5 NMAC, *EPSDT Case Management*; "medically at risk" is defined as those eligible recipients who have a diagnosed physical or behavioral health condition that has a high probability of impairing their cognitive, emotional, neurological, social, behavioral, or physical development;

(5) **case management services for eligible recipient adults with developmental disabilities:** case management services provided to eligible recipient adult members (21 years of age or older) who are developmentally disabled, as detailed in 8.326.2 NMAC, *Case Management Services for Adults with Developmental Disabilities*; and

(6) **case management services for the chronically mentally ill (SE only):** case management services provided to adults who are 18 years of age or older and who are chronically mentally ill, as detailed in 8.326.4 NMAC, *Case Management Services for the Chronically Mentally Ill*.

D. **Emergency services :** The benefit package includes emergency and post-stabilization care services for an eligible recipient. Emergency services are inpatient and outpatient services that are furnished by a qualified service provider and that are needed to evaluate or stabilize an emergency condition of an eligible recipient. An emergency condition shall meet the definition of emergency, as set forth in 8.307.1.7 NMAC, *definitions*. The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Emergency services shall be provided in accordance with Subsection F of 8.307.7.11

NMAC, *diagnostic imaging and therapeutic radiology services*. Post-stabilization care services are covered services related to an emergency condition that are provided after an eligible recipient is stabilized in order to maintain the stabilized condition or to improve or resolve the eligible recipient's condition, such that within reasonable medical probability, no material deterioration of the member's condition is likely to result from or occur during discharge of the eligible recipient or transfer of the eligible recipient to another facility.

E. **Health education and preventive services:** The MCO shall provide a continuous program of health education without cost to an eligible recipient. Such a program includes**:**

(1) publications, media, presentations, and classroom instruction;

(2) programs of wellness education;

(3) preventive service available to an eligible recipient; the MCO shall periodically remind and encourage an eligible recipient to use benefits, including physical examinations, that are available and designed to prevent illness;

(4) initiate targeted prevention initiatives for an eligible recipient with acute and chronic disease; and

(5) develop policies and procedures that encourage the proactive performance of home safety evaluations for all at-risk an eligible recipient transitioning from institutions to community settings.

F. **Inpatient hospital services :** The benefit package includes hospital inpatient acute care, procedures and services, as set forth in 8.311.2 NMAC, *Hospital Services*. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the eligible recipient mother and the eligible recipient newborn. Health coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both the eligible recipient mother and the eligible recipient newborn.

G. **Pharmacy services:** The benefit package includes all pharmacy and related services, as set forth in 8.324.4 NMAC, *Pharmacy Services*.

(1) The MCO and the SE shall cover brand name drugs and drug items not generally on their formulary or PDL when determined to be medically necessary by the MCO or the SE or through an HSD fair hearing process or a MCO or SE appeal process. The MCO shall include on its formulary or PDL all covered multi-source generic drug items with the exception of items consisting of more than one therapeutic ingredient, aanti-obesity items, and cough, cold and allergy medications; all of which may be limited to one or items at the discretion of the MCO. Items for cosmetic purposes or which are not medically necessary need not be on the PDL. The MCO shall reimburse family planning clinics, school-based health clinics, and DOH public health clinics for oral contraceptive agents and Plan B when dispensed to and eligible recipient and billed using HCPC codes and CMS 1500 claim forms. The MCO and the SE shall ensure that a Native American eligible recipient accessing the pharmacy benefit through an Indian health services or a tribal 638 pharmacy facility will be exempt from the preferred drug listing.

(2) The MCO shall use a PDL developed with consideration of the clinical efficiency, safety and cost effectiveness of drug items, and shall provide medically appropriate drug therapies for an eligible recipient. Drug items not on the PDL must be considered for coverage on a prior authorization basis. Upon development, the MCO will be required to deliver its pharmacy benefit package using a single MAD approved PDL.

(a) The MCO and the SE shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal requirements and state rules and statutes.

(b) The MCO and the SE shall coordinate the delivery of the pharmacy benefit when medicare part D is the primary coverage.

(c) The MCO shall ensure that any eligible recipient who takes nine or more different prescription medications has his or her medications reviewed by a medical clinician for appropriateness and the identification and correction of potentially harmful practices, and shall document this review in the eligible recipient's chart at least every six months.

(3) The MCO's preferred drug list (PDL) shall also use the following guidelines:

(a) there must be at least one representing drug for each of the therapeutic categories in the first data bank blue book;

(b) generic substitution shall be based on "AB" rating or clinical need;

(c) for a multiple source, brand name product within a therapeutic class, the MCO may select a representative drug;

(d) the PDL shall follow the centers for medicare and medicaid services (CMS) special guidelines relating to drugs used to treat HIV infection;

(e) the PDL shall include coverage of over the counter (OTC) drugs prescribed by a licensed practitioner as indicated in 8.324.4 NMAC *Pharmacy Serivces*; and

(f) the MCO shall implement an appeals process for service providers who believe that an exception to the PDL should be made for an eligible recipient.

H. **Pregnancy termination services:** The benefit package provides a pregnant eligible recipient coverage for a pregnancy termination under specific situations and based on these situations, reimbursement is made in accordance with 42 CFR Section 441.202 or through state-funding which is excluded from the capitation payment to the MCO. See 8.325.7 NMAC, *Pregnancy Termination*,

I. **Preventive health services:** The benefit package provides for an eligible recipient the following preventive health services.

(1) **Immunizations:** The MCO shall ensure that, within six months of enrollment, an eligible recipient is current with immunizations according to the type and schedule provided by the most recent version of the recommendations of the advisory committee on immunization practices (ACIP) of the centers for disease control and prevention, public health service, U.S. department of health and human services. This may be done by providing the necessary immunizations or by verifying the immunization history by a method deemed acceptable by the ACIP. "Current" is defined as no more than four months overdue.

(2) **Screens:** The MCO shall ensure that, to the extent possible, an asymptomatic eligible recipient receives and is current for at least the following screening services within six months of enrollment or within six months of a change in the standard. The MCO shall require its network providers to perform the appropriate interventions based on the results of the screens. "Current" is defined as no more than four months overdue. The MCO shall ensure that clinically appropriate follow-up or intervention is performed when indicated by the screening results.

(a) **Screening for breast cancer:** The benefit package provides for an eligible woman recipient age 50 and above who is not at high risk for breast cancer shall be screened annually with mammography and a clinical breast examination. An eligible female recipient of any age at high risk for developing breast cancer shall be screened as often as clinically indicated.

(b) **Screening for cervical cancer:** The benefit package provides for an eligible female recipient with a cervix to receive papanicolaou (PAP) testing starting at the onset of sexual activity, but at least by 18 years of age, and every three years thereafter, if prior testing has been consistently normal and the eligible recipient has been confirmed to be not at high risk. If the eligible recipient is at high risk, the testing frequency shall be at least annually.

(c) **Screening for colorectal cancer:** The benefit package provides for an eligible recipient age 50 and older at normal risk for colorectal cancer to be screened with annual fecal occult blood testing or sigmoidoscopy at a periodicity determined by the MCO.

(d) **Blood pressure measurement:** The benefit package provides for any eligible recipient to receive a blood pressure measurement as medically indicated.

(e) **Serum cholesterol measurement:** The benefit package provides for any eligible male recipient age 35 and above and for an eligible woman recipient age 45 and above who is at normal risk for coronary heart disease to receive serum cholesterol measurement every five years. An eligible recipient with multiple risk factors shall also receive HDL-C measurement.

(f) **Screening for obesity:** The benefit package provides for any eligible recipient to receive annual body weight and height measurements to be used in conjunction with a calculation of the body mass index or referenced to a table of recommended weights.

(g) **Screening for elevated lead levels:** The benefit package provides for an eligible recipient age nine to 15 months (ideally 12 months old) to receive a blood lead measurement at least once.

(h) **Screening for diabetes:** The benefit package provides for an eligible recipient to receive a fasting or two-hour post-prandial serum glucose measurement as medically indicated.

(i) **Screening for tuberculosis:** The benefit package provides for an eligible recipient to receive a tuberculin skin test based on the level of individual risk for development of the infection.

(j) **Screening for rubella:** The benefit package provides for an eligible female recipient of childbearing age to be screened for rubella susceptibility by history of vaccination or by serology.

(k) **Screening for visual impairment:** The benefit provides for an eligible recipient three to four years of age to be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test.

(l) **Screening for hearing impairment:** The benefit package provides for an eligible recipient age 50 and older to be routinely screened for hearing impairment by questioning [~~them~~] the eligible recipient about their hearing.

(m) **Screenings for alcohol and drug usage:** The benefit package provides for an eligible adolescent recipient and for an eligible adult recipient to receive at least one time an alcohol and drug screening. The screening may be conducted either by a careful review of the patterns of alcohol and/or drug utilization of the eligible recipient or by the use of a standardized screening questionnaire. These may include the alcohol use disorders identification test (AUDIT); the four-question CAGE instrument; or the substance abuse screening severity inventory (SASSI). The frequency of screening shall be determined by the results of the first screen and other clinical indications. An eligible recipient may be referred by his/her provider for or may self-refer for behavioral health services provided by the SE.

(n) **Prenatal screening:** The benefit package provides for an eligible recipient to be screened for preeclampsia, D (Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, and vaginal and rectal group B streptococcal infection; and counseled and offered testing for HIV.

(o) **Newborn screening:** The benefit package provides at a minimum, for an eligible newborn recipient to be screened for phenylketonuria, congenital hypothyroidism, galactosemia, and any other congenital disease or condition specified in accordance with department of health regulations, specifically 7 NMAC 30.6, *Newborn genetic screening program*.

(p) **Behavioral health screening:** The benefit package provides for an eligible recipient to be receive a behavioral health screening during an encounter with his/her primary care provider (PCP).

(3) **Non-behavioral health counseling services:** The benefit package provides for an asymptomatic eligible recipient, as applicable, to receive counseling and guidance on the following unless the eligible recipient's refusal is documented:

(a) prevention of tobacco use; promotion of physical activity;

(b) promotion of healthy diet;

(c) prevention of osteoporosis and heart disease, including a menopausal woman;

(d) prevention of motorized vehicle injuries;

(e) prevention of household and recreational injuries;

(f) prevention of dental and periodontal disease;

(g) prevention of HIV infection and other sexually transmitted diseases; and

(h) prevention of an unintended pregnancy.

(4.) **Health advisor hotline:** The MCO shall provide a toll-free health advisor hotline, which shall provide at least the following:

(a) general health information on topics appropriate to the various MCO populations, including those with severe and chronic conditions;

(b) clinical assessment and triage to evaluate the acuity and severity of the eligible recipient's symptoms and make the clinically appropriate referral; and

(c) pre-diagnostic and post-treatment service decision assistance based on symptoms.

(5) **Family planning policy:** The MCO shall have a written family planning policy to ensure that eligible recipients of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to the following: methods of contraception; evaluation and treatment of infertility; risk reduction practices for HIV and other sexually transmitted diseases; options for pregnant eligible recipients.

(6) **Prenatal care program:** The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal services consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(a) educational outreach to any eligible female recipient of childbearing age;

(b) prompt and easy access to obstetrical services, including providing an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(c) risk assessment of every eligible pregnant recipient to identify high risk cases for special management;

(d) counseling that strongly advises voluntary testing for HIV;

(e) case management services to an eligible recipient of a high risk pregnancy to address special needs of the eligible pregnant recipient, especially if the risk is due to psychosocial factors such as substance abuse or a teen pregnancy;

(f) screening to determine the need of a post-partum home visit; and

(g) coordination with other services in support of good prenatal care, including transportation and other community services and referral to an agency that dispenses free or reduced price baby car seats.

J. **Reproductive health services:** The benefit package provides reproductive health services for an eligible recipient. See 8.325.3 NMAC, *Reproductive Health Services*.

(1) The MCO shall provide through its practitioners sufficient information to an eligible recipient to assist him/her make informed reproductive health decisions.

(2) An eligible female recipient shall have the right to self-refer to a woman's health specialist within the MCO's provider network for covered services necessary to provide routine and preventive reproductive health care services. This right of self-refer is in addition to the eligible recipient's designated source of primary care if that source is not a women's health specialist.

(3) The MCO will maintain a formal written family planning policy and ensure through its practitioners that an eligible recipient seeking family planning services will provide counseling (non-behavioral) and non-bias information pertaining to the following:

(a) methods of contraception, including sterilizations for an eligible male and a female recipient of childbearing age;

(b) the types of family planning services available;

(c) the eligible recipient's right to access these services in a timely and confidential manner;

(d) the freedom to choose a qualified family planning provider;

(e) risk reduction practices for HIV infection and other sexually transmitted diseases; and

(f) counseling and non-bias information for pregnancy termination options, see .325.7 NMAC *Pregnancy Termination Procedures*.

K.. **School-based services:** The benefit package provides an eligible recipient those services provided in schools, excluding those specified in the eligible recipient's individualized education plan (IEP) or individualized family service plan (IFSP), as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*.

L.. **Service coordination:** The benefit package provides an eligible recipient service coordination that is person-centered and the intent is to support the eligible recipient pursue desired life outcomes by assisting him/her access support and services necessary to achieve the quality of life desired in a safe and healthy environment. Service coordination assists an eligible recipient gain access to needed coordination of CoLTS 1915 (b) and 1915 (c) waiver services and other necessary services, regardless of the funding source.

K. **Transportation services:** The benefit package provides for an eligible recipient to access transportation services such as ground ambulance, air ambulance, taxicab or handivan, commercial bus, commercial air, meal, and lodging services, as indicated for medically necessary physical and behavioral health services, as set forth in 8.324.7 NMAC *Transportation Services*. In addition, the MCO must abide by New Mexico laws, statutes and regulations, specifically NMSA 1978 Section 65-2-97(F), stating that rates paid by the MCO to transportation providers are not subject to and are exempt from New Mexico public regulation commission approved tariffs. The MCO is also required to coordinate, manage and be financially responsible for the delivery of the transportation benefit to an eligible recipient receiving physical health services or behavioral health services.

[8.307.7.11 NMAC - N, 8-1-08; A, 9-1-09; A, 5-1-10; A, 12-15-10; A, 7-1-12]

8.307.7.12 [~~BEHAVIORAL HEALTH SERVICES:~~ ~~Behavioral health services provided by the CoLTS MCO's network providers will be covered by the CoLTS MCO, even when the primary diagnosis is a behavioral health diagnosis. Facility costs, including emergency room costs, will be covered by the CoLTS MCO unless there is a specific psychiatric revenue code on the facility claim form. Any professional services provided by a behavioral health service provider in an emergency room or in an inpatient or outpatient hospital setting will be covered by the SE. Any services provided by a physical health service provider in an emergency room or in an inpatient setting will be covered by the CoLTS MCO. The SE will cover outpatient hospital services that require the use of a psychiatrist or psychologist revenue code for billing. Pharmacy claims prescribed by a physical health service provider will be covered by the CoLTS MCO.~~] [RESERVED]

[8.307.7.12 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

8.307.7.13 [~~BEHAVIORAL HEALTH SERVICES INCLUDED IN THE BENEFIT PACKAGE FOR ADULTS AND CHILDREN.~~ ~~The SE shall cover the following medicaid services. If, at any time, other medicaid behavioral health services are included in the state plan or a state plan amendment, the SE shall cover those services also.~~

~~A. **Inpatient hospital services:** The benefit package includes inpatient hospital psychiatric services provided in general hospital units and prospective payment system (PPS) exempt units in a general hospital as detailed in 8.311.2 NMAC, *Hospital Services.*~~

~~B. **Hospital outpatient services:** The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt units of general hospitals as detailed in 8.311.4 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*.~~

~~C. **Outpatient health care professional services:** The benefit package includes outpatient health care services, as detailed in 8.310.8 NMAC, *Mental Health Professional Services*.~~

~~D. **Comprehensive community support services:** The benefit package includes comprehensive community support services as detailed in 8.315.6 NMAC, *Comprehensive Community Support Services.*~~

~~E. **Assertive community treatment services (ACT):** The benefit package includes assertive community treatment services for members eighteen (18) years of age and older as detailed in 8.315.5 NMAC, *Assertive Community Treatment Services*.~~] **COORDINATION WITH THE BEHAVIORAL HEALTH SINGLE ENTITY (SE):** The CoLTS MCO and the SE are to ensure an eligible recipient's physical and behavioral health services are coordinated and not duplicative. An eligible recipient enrolled in a 1915 (b) or (c) waiver program may access all appropriate MAD behavioral health services provided under the SE's contract. Under specific situations, the SE will be responsible for the service rather than the CoLTS MCO. The CoLTS MCO will:

(1) receive information from and provide information to the SE regarding an eligible recipient and a service provider;

(2) meet with the SE to resolve provider and recipient issues to improve services, communication and coordination;

(3) maintain and distribute statistical information and data as required under the MCO contract.

A. A behavioral health service rendered by a physical health provider will be covered by the MCO, even when the primary diagnosis is behavioral health subject to the MCO network/out of network provider requirements. Any payment for a service following medicare payment or payment by a medicare replacement plan is the responsibility of the CoLTS MCO, whether for behavioral health or physical health. Any services provided by a physical health service provider in an emergency room or in an inpatient setting will be covered by the CoLTS MCO.

B. Transportation services to a behavioral health service are the responsibility of the CoLTS MCO. The MCO will coordinate with the SE when providing transportation out of the eligible recipient's home community, such as out-of-home placement.

C. Laboratory services ordered by a behavioral health provider for an eligible recipient are the CoLTS MCO responsibility when:

(1) the lab work performed by an outside, independent laboratory or a non-behavioral health provider. The SE is responsible for lab work when performed by a behavioral health provider such as, a freestanding psychiatric hospital, a psychiatric unit, a psychiatric unit within a general hospital.

(2) the eligible recipient is under treatment in a freestanding psychiatric hospital.

D. Pharmacy benefits for an eligible recipient are the SE's responsibility under specific situations. The SE shall be responsible for payment of all drug items prescribed by a behavioral health provider, such as a psychiatrist, psychologist, psychiatric clinical nurse specialist, and a psychiatric nurse practitioner, certified to prescribe and contracted through the SE.

[8.307.7.13 NMAC- N, 8-1-08; A, 7-1-12]

~~8.307.18.14 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE CoLTS BENEFIT PACKAGE FOR CHILDREN ONLY:~~ ~~The SE shall provide the following medicaid services. The benefit package includes prevention, screening, diagnostic, ameliorative services and other medically necessary behavioral health care and substance abuse treatment or services for medicaid members under 21 years of age whose need for behavioral health services is identified by a licensed health care provider or during an EPSDT screen. All behavioral health care services shall be provided in accordance with the current New Mexico Children's Code and the Children's Mental Health and Developmental Disabilities Act, NMSA Section 32A-6-1 to 32A-6-22. The services include the following:~~

~~A. **Inpatient hospitalization in free standing psychiatric hospitals:** The benefit package includes inpatient services in free standing psychiatric hospitals as detailed in 8.321.2 NMAC, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals*.~~

~~B. **Accredited residential treatment center services:** The benefit package includes accredited residential treatment services as detailed in 8.321.3 NMAC, *Accredited Residential Treatment Center Services*.~~

~~C. **Non-accredited residential treatment centers and group homes:** The benefit package includes residential treatment services as detailed in 8.321.4 NMAC, *Non-Accredited Residential Treatment Centers and Group Homes*.~~

~~D. **Treatment foster care:** The benefit package includes treatment foster care services as detailed in 8.322.2 NMAC, *Treatment Foster Care*.~~

~~E. **Treatment foster care II:** The benefit package includes treatment foster care II, as detailed in 8.322.5 NMAC, *Treatment Foster Care II*.~~

~~F. **Outpatient and partial hospitalization services in freestanding psychiatric hospital:** The benefit package includes outpatient and partial hospitalization services provided in freestanding psychiatric hospitals, as detailed in 8.321.5 NMAC, *Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals*.~~

~~G. **Day treatment services:** The benefit package includes day treatment services, as detailed in 8.322.4 NMAC, *Day Treatment Services*.~~

~~H. **Behavior management skills development services (BMSDS):** The benefit package includes behavior management services, as detailed in 8.322.3 NMAC, *Behavior Management Skills Development Services*.~~

~~I. **School-based services:** The benefit package includes counseling, evaluation and therapy furnished in a school-based setting, but not when specified in the individual education plan (IEP) or the individualized family service plan (IFSP), as detailed in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*.~~

~~J. **Licensed alcohol and drug abuse counselors:** The benefit package includes alcohol and drug abuse counseling, as detailed in 8.310.8 NMAC, *Behavioral Health Professional Services*.~~

~~K. **Multi-systemic therapy services:** The benefit package includes multi-systemic therapy services, as detailed in 8.322.6 NMAC, *Multi-Systemic Therapy Services*.~~] **MONEY FOLLOWS THE PERSON (MFP):** MFP is a demonstration grant administered by CMS. During the grant period, grantee states use available funding to facilitate transitions from qualified institutions to qualified community settings that are covered under CoLTS when New Mexico has been authorized by CMS as a grantee state and when the state exercises the option to utilize the grant. MFP participants must meet specific CMS criteria referenced in the CMS grant terms and conditions and the CMS approved state MFP operational protocol (OP). The definition for qualified eligible individuals, institutions and community settings are detailed in the OP. The MCO may assess the use of MFP grant demonstration, supplemental or MCO enhanced or value added transition goods and services when an eligible recipient in coordination with the CoLTS 1915 (c) HCBS transition goods and services

[8.307.7.14 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

8.307.7.15 [~~BEHAVIORAL HEALTH SERVICES INCLUDED IN THE BENEFIT PACKAGE FOR ADULTS ONLY:~~ ~~The benefit package includes psychosocial rehabilitation, as detailed in 8.315.3 NMAC Psychosocial Rehabilitation Services, and shall be provided by the SE, in accordance with the New Mexico Mental Health and Developmental Disabilities Code, NMSA Sections 43-1-1 to 43-1-25.~~] **COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER:** The following are services available to a MAD eligible recipient who is enrolled in the CoLTS 1915 (c) HCBS waiver. To be eligible for enrollment in the CoLTS 1915 (c) HCBS waiver program, a recipient must meet specific criteria, see long-term care services utilization review instructions for NF LOC. For additional information on the CoLTS 1915 (c) HCBS waiver**, see** 8.307.18 NMAC, *CoLTS 1915 (C) Home and Community Based Services Waiver*.

[8.307.7.15 NMAC - N, 8-1-08; A, 7-1-12]

8.307.7.16 SERVICES EXCLUDED FROM THE COLTS 1915 (B) BENEFIT PACKAGE: [~~The following services are not included in the coordination of long-term services program benefit package.~~] For an eligible recipient enrolled in a CoLTS1915 (b) waiver program, the following are non-covered services:

A. services provided in intermediate care facilities for the mentally retarded (ICF/MR), as set forth in 8.313.2 NMAC, *Intermediate Care Facilities for the Mentally Retarded*;

B. emergency services to undocumented aliens, as set forth in 8.325.10 NMAC, *Emergency Services for Undocumented Aliens*;

C. experimental or investigational procedures, technologies or non-drug therapies, as set forth in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies*;

D. case management services provided by the children, youth and families department that are defined as child protective services case management, as set forth in 8.320.5 NMAC, *EPSDT Case Management*;

E. case management services provided by the aging and long-term services department, as set forth in 8.326.7 NMAC, *Adult Protective Services Case Management*;

F. case management services provided by the children, youth and families department, as set forth in 8.326.8 NMAC, *Case Management Services for Children Provided by Juvenile Probation and Parole Officers*;

G. services provided in the schools and specified in the IEP or IFSP, as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*; and

[~~H. services provided under the home and community-based waiver services programs, as set forth in 8.314.2 NMAC, *Disabled and Elderly Home and Community-Based Services Waiver*, the medically fragile waiver, HIV/AIDS waiver, developmentally disabled waiver, and mi via waiver.~~]

H. For an eligible recipient enrolled in a CoLTS 1915 (b) waiver program, the eligible recipient is not eligible to receive services provided thru the following 1915 (c) waiver programs. These include:

(1) the disabled and elderly waiver;

(2) the developmentally disabled waiver;

(3) the AIDS waiver; and

(4) the medically fragile waiver.

[8.307.7.16 NMAC - N, 8-1-08; A, 9-1-09; A, 7-1-12]

8.307.7.17 VALUE ADDED OR ENHANCED SERVICES: See [~~8.307.17 NMAC~~] 8.307.1 NMAC, *General Provisions*.

[8.307.7.17 NMAC - N, 8-1-08; A, 7-1-12]

HISTORY OF 8.307.7 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 312 LONG TERM CARE SERVICES - NURSING SERVICES
PART 2 NURSING FACILITIES

8.312.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[2/1/95; 8.312.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 6/15/10; A, 7/1/12]

8.312.2.3 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 NMSA 1978 Sections 27-2-12 et seq. NMSA 1978 [(Repl. Pamp. 1991).~~] The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[2/1/95; 8.312.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 6/15/10; A, 7/1/12]

8.312.2.6 OBJECTIVE: [~~The objective of 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.~~] The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[2/1/95; 8.312.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6 & A, 6/15/10; A, 7/1/12]

8.312.2.8 MISSION STATEMENT: [~~To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.~~] To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[2/1/95; 8.312.2.8 NMAC - Rn, 8 NMAC 4.MAD.002 & A, 6/15/10; A. 7/1/12]

8.312.2.9 NURSING FACILITIES: [~~The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including services furnished in nursing facilities. See 42 Section CFR 440.40. This part describes provider eligibility, covered services, service limitations, recipient fund accounts, and general reimbursement methodology.~~] The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for services furnished in nursing facilities.
[2/1/95; 8.312.2.9 NMAC - Rn, 8 NMAC 4.MAD.731, 6/15/10; A, 7/1/12]

8.312.2.10 ELIGIBLE PROVIDERS:

[~~**A.** Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), nursing facilities (NF) which meet the following conditions are eligible to be reimbursed for providing services to medicaid recipients: 1) be licensed and certified by the licensing and certification bureau of the department of health (DOH) to meet medicaid nursing facility conditions of participation. See 42 CFR Part 483, as amended; 2) conform to policy regarding medicaid recipients' personal funds; 3) participate in the MAD utilization review process and agree to operate in accordance with all policies and procedures of that system, including the performance of discharge planning; 4) adhere to the rules and regulations relating to the pre-admission screening and resident review (PASRR) of mentally ill and mentally retarded program; 5) conform to the rules and regulations relating to nurse aide training; and 6) facilities with sixty (60) or more medicaid beds must certify a minimum of four (4) distinct beds in the medicare program.~~

~~(1) This requirement can be waived if the NF meets one (1) of the following conditions:~~

~~(a) the NF is located in a rural area and is unable to attract therapists as required by the medicare program; for a waiver to be granted under this condition, the provider must prove that good faith efforts to hire or contract with the required therapists have been made;~~

~~(b) the NF has obtained a waiver of the RN staffing requirement from the DOH, in accordance with applicable federal regulations; or~~

~~(c) the NF is one of two or more NF in the same town owned or operated by the same owner/manager and one of the other facilities is medicare-certified; in addition, the NF must demonstrate on a yearly basis that the waiver does not hinder access to medicare part A services for medicaid-eligible recipients and that the~~

~~facility is using, to the best of its ability, corridor billings to medicare for part B services(s); if medicare removes the ability to do corridor billing, the waiver automatically ceases.~~

~~(2) Any requests for a waiver must contain sufficient documentation to support the request and must be submitted in writing to MAD.~~

~~(3) Medicare is the primary payer for NF services covered under the medicare program.~~

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

~~(1) **Appeals process for denial, termination or non-renewal of participation:** See Section MAD-967.5, Appeals of Denial, Termination, or Non-renewal of Provider Participation.~~

~~(2) **Sanctions and Incentives:** See Section MAD-967.5, Incentives for Nursing Facilities. See Section MAD-967, Sanctions for Non-Compliance, Section MAD-968, Intermediate Remedies for Non-Compliance.~~] Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. Nursing facilities (NF) which:

(1) are currently licensed and certified by the department of health (DOH) to meet MAD nursing facility conditions of participation. See 42 CFR Part 483, as amended;

(2) comply with the MAD recipients' personal funds rules;

(3) comply with the MAD utilization review process and agree to operate in accordance with all MAD rules, including the performance of discharge planning;

(4) comply with the MAD rules for the pre-admission screening and resident review (PASRR) of mentally ill and intellectually disabled program;

(5) ensure the required nurse aide training is implemented; and

(6) ensure that facilities with 60 or more MAD beds certify a minimum of four distinct beds in the medicare program.

B. The above requirements can be waived if the NF meets one of the following conditions:

(1) the NF is located in a rural area and is unable to attract therapists as required by the medicare program; for a waiver to be granted under this condition, the provider must prove that good faith efforts to hire or contract with the required therapists have been made;

(2) the NF has obtained a waiver of the RN staffing requirement from DOH, in accordance with applicable federal regulations; or

(3) the NF is one of two or more NFs in the same town owned or operated by the same owner/manager and one of the other facilities is medicare-certified; in addition, the NF must demonstrate on a yearly basis that the waiver does not hinder access to medicare part A services for medicaid-eligible recipients and that the facility is using, to the best of its ability, corridor billings to medicare for part B services(s); if medicare removes the ability to do corridor billing, the waiver automatically ceases.

(i) Any requests for a waiver must contain sufficient documentation to support the request and must be submitted in writing to MAD.

(ii) Medicare is the primary payer for NF services covered under the medicare program.

C. Services must be provided within the scope of the practice and licensure for each provider and must be in compliance with the statutes, rules and regulations of the applicable practice and with the MAD program policy manual.

[2/1/95; 8.312.2.10 NMAC - Rn, 8 NMAC 4.MAD.731.1, 6/15/10; A, 7/1/12]

8.312.2.11 PROVIDER RESPONSIBILITIES: [~~Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See Section MAD-701, General Provider Policies [8.302.1 NMAC, 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 furnished to recipients. See Section MAD-701, General Provider Policies [8.302.1 NMAC, General Provider Policies~~].

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services. See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.312.2.11 NMAC - Rn, 8 NMAC 4.MAD.731.2, 6/15/10; A, 7/1/12]

8.312.2.12 REQUIRED NURSING FACILITY SERVICES: Nursing facilities are required to provide the following to a MAD eligible recipient resident:

A. room and board;

B. professional nursing services [~~twenty-four (24)~~] 24 hours a day, seven [~~(7)~~] days a week; professional nursing services are those services which are performed directly by a registered nurse (RN) or a licensed practical nurse (LPN), under the direction of a medical practitioner;

C. services of an RN on an eight [~~(8)~~] hours a day, seven [~~(7)~~] days a week basis, and at least the services of a LPN at all other times; and

D. [~~personal assistance services on a twenty-four (24) hours a day, seven (7) days a week basis; personal assistance services are those services, other than professional nursing services, which can be needed by an individual because of age, infirmity, physical or mental limitations, and/or dependence in accomplishing the activities of daily living.~~] personal assistance services on a 24 hours a day, seven days a week basis; personal assistance services are those services, other than professional nursing services, that are provided to an eligible recipient who, because of age, infirmity, physical or behavioral health limitations, requires assistance to accomplish activities of daily living.

[2/1/95; 8.312.2.12 NMAC - Rn, 8 NMAC 4.MAD.731.3, 6/15/10; A, 7/1/12]

8.312.2.13 COVERED SERVICES:

[~~**A.** Medicaid covers NF services identified as allowable costs. See Section MAD-731-D, Cost Related Reimbursement of Nursing Facilities, Section III.G [Subsection G of 8.312.3.11 NMAC, Cost Related Reimbursement of Nursing Facilities].~~

~~**B.** Medicaid covers physical, occupational and speech therapy services furnished to medicaid residents in the following manner:~~

~~(1) if the resident is also eligible for medicare and the facility does part B billing, the co-payment for services is paid by medicaid;~~

~~(2) if the resident receives high NF level services, services are included in the medicaid facility rate; or~~

~~(3) if the resident receives low NF level services, services are billed separately by participating therapy providers.~~]

A. MAD covers NF services identified as allowable costs. See 8.312.3 NMAC *Cost Related Reimbursement of Nursing Facilities*.

B. MAD covers physical, occupational and speech therapy services furnished to an eligible recipient residing in a NF in the following manner:

(1) if the eligible recipient is also eligible for medicare and the facility does part B billing, the co-payment, co-insurance and deductible are processed by MAD for services;

(2) if the eligible recipient receives high NF level services, services are included in the MAD facility rate; or

(3) if eligible the recipient the receives low NF level services, services are billed separately by participating therapy providers.

[2/1/95; 8.312.2.13 NMAC - Rn, 8 NMAC 4.MAD.731.4, 6/15/10; A, 7/1/12]

8.312.2.14 NONCOVERED SERVICES: [~~Medicaid does not cover services which are not included as allowable costs. See Section MAD-731 D, Cost Related Reimbursement of Nursing Facilities, Section III.G [Subsection G of 8.312.3.11 NMAC, Cost Related Reimbursement of Nursing Facilities]. See Section MAD-753, Pharmacy Services [8.324.4 NMAC, Pharmacy Services], for covered pharmacy services which are billed directly by pharmacy providers.~~] NF services are subject to the limitations and coverage restrictions which exist for other MAD services. See also 8.301.3 NMAC, *General Noncovered Services*; Subsection 11 of 8.312.3.11 NMAC, *determination of actual, allowable and reasonable costs and setting of prospective rates*; and 8.324.4 NMAC, *Pharmacy Rules*, for covered pharmacy services which are billed directly by pharmacy providers.

[2/1/95; 8.312.2.14 NMAC - Rn, 8 NMAC 4.MAD.731.5, 6/15/10; A, 7/1/12]

8.312.2.15 RECIPIENT PERSONAL FUND ACCOUNTS:

A. As a condition for MAD provider participation [~~in medicaid~~], each NF must establish and maintain an acceptable system of accounting for [~~a resident's~~] a MAD eligible recipient resident's personal funds when a [~~Title XIX (medicaid)~~] MAD eligible recipient requests that his or her personal funds be cared for by the facility. See 42 CFR Section 483.10(c). See Subsection D of 7.9.2.22 NMAC.

(1) Requests for [~~NFs~~] a NF to care or not care for [~~a resident's~~] an eligible recipient resident's funds must be made in writing and secured by a request to handle recipient funds form or letter signed by the eligible recipient or his or her authorized representative. The form or letter is kept in the eligible recipient's file at the facility.

(2) [~~A recipient's~~] An eligible recipient's personal fund consists of a monthly maintenance allowable, established by MAD. If the eligible recipient resident receives any income in excess of this allowance, the excess is applied to the cost of the eligible recipient resident's medical care at the facility. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) [~~All facilities~~] A NF must have procedures on the handling of [~~medicaid~~] eligible recipient residents' funds. These procedures must not allow the facility to commingle [~~medicaid~~] eligible recipient residents' funds with facility funds.

(4) [~~Nursing facilities~~] A NF should use these [~~medicaid guidelines~~] applicable federal regulations and state rules to develop procedures for handling resident funds.

(5) [~~Resident have~~] An eligible recipient resident has the right to manage [~~their~~] his/her financial affairs and no facility can require [~~residents~~] an eligible recipient resident to deposit [~~their~~] his/her personal funds with the facility.

(6) [~~Facilities~~] A NF must purchase a surety bond or furnish self-insurance to ensure the security of all personal funds deposited with the facility.

(7) Failure of a NF to furnish an acceptable accounting system constitutes a deficiency that must be corrected by the provider and verified by DOH survey teams.

B. Fund custodians: [~~Nursing facilities~~] A NF must designate a full-time employee and an alternate to serve as fund custodians for handling [~~all medicaid residents'~~] an eligible recipient resident's money on a daily basis. See 7.9.2.22D NMAC.

(1) Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(a) reconcile balances of [~~the individual medicaid residents'~~] each eligible recipient's accounts with the collective bank account;

(d) periodically audit and reconcile the petty cash fund; and

(c) authorize checks for the withdrawal of funds from the bank account.

(2) [~~Facilities~~] A NF must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each resident's personal funds entrusted to facilities on the eligible recipient resident's behalf.

C. Bank account: [~~Nursing facilities must establish a bank account for the deposit of all money for medicaid residents who request requests the facility to handle their funds. Residents' personal funds are held separately and not commingled with facility funds.~~] A NF must establish a bank account for the deposit of all money for each eligible recipient resident who requests the NF to handle his/her funds. An eligible recipient's personal funds are to be held separately and not commingled with the NF funds. See 7.9.2.22D NMAC.

(1) [~~Facilities~~] A NF must deposit any eligible recipient resident's personal funds of more than [~~fifty ($50)~~] dollars in an interest bearing account that is separate from any of the [~~facility~~] NF operating accounts and which credits all interest earned on the eligible recipient resident's account to that account. Residents must have convenient access to these funds.

(2) [~~Facilities must maintain eligible recipient residents' personal funds up to fifty ($50) in an interest bearing account or a petty cash fund. Residents must have convenient access to these funds.~~] A NF must maintain an eligible recipient resident's personal funds up to $50 in an interest bearing account or a petty cash fund. An eligible recipient resident must have convenient access to these funds.

(3) [~~Individual financial records must be available on the request of residents or their legal representatives.~~] Individual financial records must be available on the request of an eligible recipient resident or his/her legal representative.

(4) Within [~~thirty (30)~~] 30 calendar days of the death of [~~residents~~] an eligible recipient resident whose personal funds are deposited with the facility, a NF must convey the deceased eligible recipient resident's funds and a final accounting of these funds to the individual or probate jurisdiction administering the deceased eligible recipient resident's estate.

D. Establishment of individual accounts: [~~Nursing facilities~~] A NF must establish accounts for each [~~medicaid~~] eligible recipient resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file or looseleaf binder. See 7.9.2.22D NMAC.

(1) For money received, the source, amount and date must be recorded. [~~Residents or their authorized representatives must be given receipts for the money.~~] The NF must provide the eligible recipient resident or his/her representative receipts for the money. The NF retains a copy of the deposit in the eligible recipient resident's individual account file.

(2) [~~The purpose, amount and date of all disbursements to or on behalf of residents must be recorded. All money spent either on behalf of residents or withdrawn by residents or their representatives must be validated by receipts or signatures on individual ledger sheets.~~] The purpose, amount and date of all disbursements to or on behalf of an eligible recipient resident must be recorded. All money spent either on behalf of the eligible recipient resident or withdrawn by the eligible recipient resident or his/her representative must be validated by receipts or signatures on each eligible recipient resident's individual ledger sheet.

(3) [~~Facilities~~] The NF must notify each [~~medicaid~~] eligible recipient resident when the account balance is [~~two hundred ($200) dollars~~] $200 less than the supplemental security income (SSI) resource limit for one [~~(1)~~] person specified in section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the eligible recipient resident's other nonexempt resources reach the SSI resource limit for one [~~(1)~~] person, the eligible recipient resident can lose eligibility for medicaid or SSI.

E. Personal fund reconciliation: The NF must balance [~~the~~] each eligible recipient resident's individual accounts, the collective bank accounts and the petty cash fund at least once each month. The NF must furnish [~~medicaid~~] each eligible recipient resident or his/her representative [~~residents or their authorized representatives~~] with an accounting of the eligible recipient residents' funds at least quarterly. Copies of each eligible recipient resident's individual account records can be used to furnish this information. See 7.9.2.22D NMAC.

F. Petty cash fund: The NF must maintain a cash fund in the facility to accommodate the small cash requirements of [~~the medicaid residents~~] an eligible recipient resident. Five dollars [~~($5.00)~~] or less per [~~individual~~] each eligible recipient resident may be adequate. The amount of money kept in the petty cash fund is determined by the number of [~~recipients~~] NF residents using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund. See 7.9.2.22D NMAC.

(1) To establish the fund, the NF must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:

(a) [~~residents or their~~] an eligible recipient resident or his/her authorized representative request small amounts of spending money;

(b) the amount disbursed is entered on [~~the~~] each eligible recipient resident's individual ledger record; and

(c) the eligible recipient resident or his/her representative signs an account record and receives a receipt.

(3) To replenish the petty cash fund, the following procedures should be used.

(a) The money left in the cash box is counted and added to the total of all disbursements made since the last replenishment; and the total of the disbursements plus cash on hand equals the beginning amount.

(b) Money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures should be used once each month:

(a) count money at hand; and

(b) total cash disbursed either from receipts or each eligible recipient resident's individual account records; the cash on hand plus total disbursements equals petty cash total.

(5) To close [~~the~~] each eligible recipient resident account, the NF should do the following:

(a) enter date of and reason for closing the account;

(b) write a check against the collective bank account for the balance shown on the each eligible recipient resident's individual account record;

(c) get signature of the [~~recipient or their~~] eligible recipient resident or his/her authorized representative on the eligible recipient resident's individual [~~recipient~~] account record, as receipt of payment; and

(d) notify the local ISD office if closure is caused by death of [~~a recipient~~] an eligible recipient resident so that prompt action can be taken to terminate assistance; within [~~thirty (30)~~] 30 days of the death of [~~recipient~~] an eligible recipient resident who has no relatives, the NF conveys the eligible recipient resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the resident's estate. See 42 CFR Section 483.10(c)(6).

G. Retention of records: All account records are retained for at least [~~three (3)~~] six years or, in case of an audit, until the audit is completed.

H. Non-acceptable uses of residents' personal funds: [~~Non-acceptable uses of residents' personal funds include the following:~~

~~(1) payment or charges for services or items covered by medicaid or medicare specified as allowable costs. See Appendix 731-D, Cost Related Reimbursement of Nursing Facilities, Section III.G [Subsection G of 8.312.3.11 NMAC, Cost Related Reimbursement of Nursing Facilities];~~] Non-acceptable uses of an eligible recipient resident's personal funds include the following:

(1) payment or charges for services or items covered by MAD or medicare specified as allowable costs. See Subsection 11 of 8.312.3.11 NMAC, *determination of actual, allowable and reasonable costs and setting of prospective rates*;

(2) difference between the NF's billed charge and the [~~medicaid~~] MAD payment; and

(3) payment for services or supplies routinely furnished by the NF, such as linens or nightgowns.

(4) [~~NFs~~] a NF cannot impose charges against eligible recipient residents' personal funds for any item or service for which payment is made by [~~medicaid~~] MAD or for any item [~~residents or their representatives~~] the eligible recipient resident or his/her representative did not request;

(5) [~~facilities~~] a NF must not require [~~residents or representatives~~] eligible recipient resident or his/her representative to request any item or service as a condition of admission or continued stay; and

(6) [~~facilities must inform residents or representatives~~] a NF must inform an eligible recipient resident or his/her representative who [~~request~~] requests noncovered items or services that there is a charge for the item and the amount of the charge.

I. Monitoring of residents' personal funds: NFs must make all files and records involving [~~resident's~~] an eligible recipient resident's personal funds available for inspection by authorized state [~~personnel~~] or federal auditors. DOH survey teams verify that a NF has established systems to account for an eligible recipient resident's personal funds, including the components described above. Failure to furnish an acceptable accounting system constitutes a deficiency that must be corrected. See Subsection D of 7.9.2.22 NMAC.

[~~(1) [The licensing and certification bureau of the] DOH verifies that NFs have established systems to account for residents' personal funds, including components described above. Failure to furnish an acceptable accounting system constitutes a deficiency that must be corrected.~~]

~~[(2)] [The human services department (HSD or its designee can complete a thorough audit of residents' personal funds accounts at HSD's discretion.]~~
[2/1/95; 8.312.2.15 NMAC - Rn, 8 NMAC 4.MAD.731.6, 6/15/10; A, 7/1/12]

8.312.2.16 RESERVE BED DAYS: [~~Medicaid~~] MAD pays to hold or reserve a bed for [~~a~~] an MAD eligible recipient resident in a [~~nursing facility~~] NF to allow for the [~~residents~~] eligible recipient resident to make a brief home visit, for acclimation to a new environment, or for hospitalization according to the limits and conditions outlined below.

A. Coverage of reserve bed days: [~~Medicaid~~] MAD covers six reserve bed days per calendar year for every long term care eligible recipient resident for hospitalization without prior approval. [~~Medicaid~~] MAD covers three reserve bed days per calendar year for a brief home visit without prior approval. [~~Medicaid~~] MAD covers an additional six reserve bed days per calendar year with prior approval to [~~enable~~] support a MAD eligible recipient resident to adjust to a new environment, as part of the discharge plan.

(1) [~~A~~] An eligible recipient resident's discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.

(2) The prior approval request must include the eligible recipient resident's name, medicaid identification number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the eligible recipient resident during the visit or placement and a written [~~physician~~] medical order for trial placement.

B. Documentation of reserve bed days: [~~When a resident leaves the NF for any reason, appropriate documentation must be placed in the resident's chart. A [physician] order must be obtained if residents are hospitalized, request home visits or trial placement.~~] When an eligible recipient resident is discharged from a NF for any reason, appropriate documentation must be placed in the eligible recipient resident's chart and discharge information sent to the eligible recipient's MCO. A medical order must be obtained if the eligible recipient resident must be obtained if the eligible recipient resident is hospitalized, requests a home visit or a trial placement.

C. Level of care determinations: A new level of care determination must be performed by the MAD utilization review (UR) contractor if [~~a~~] an eligible recipient resident is gone from the NF for more than three midnights. An abstract must be completed, including information on the reason for the eligible recipient resident's absence, outcome of the leave and any other pertinent information concerning the leave.

D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the NF is limited to the rate applicable for the level of care medically necessary for the eligible recipient resident, as determined and approved by MAD or its designee. The reserve bed day reimbursement is equal to 50 percent of the regular payment rate for [~~medicaid~~] MAD fee-for-service [~~clients~~] or as otherwise negotiated between the NF provider and the [~~medicaid~~] MAD designated contractor. Billing for reserve bed days is based on the nursing census, which runs from midnight to midnight. [~~Under normal circumstance, medicaid or the medicaid~~] MAD or its designated contractor, pays for the admission day but not for the discharge day.
[2/1/95; 8.312.2.16 NMAC - Rn, 8 NMAC 4.MAD.731.7 & A, 6/15/10; A, 7/1/12]

8.312.2.17 LEVEL OF CARE DETERMINATION: Medical necessity, level of care, and length of stay determinations are carried out in accordance with MAD utilization review (UR) policy and procedures, as authorized under Title XIX of the Social Security Act. [~~See Section MAD-705, Prior Approval and Utilization Review [8.302.5 NMAC, Prior Authorization and Utilization Review]. See Section MAD-955, Reconsideration of Level of Care Determinations [8.350.4 NMAC, Reconsideration of Audit Settlements.~~] See 8.302.5 NMAC, *Prior Authorization and Utilization Review* and 8.350.4 NMAC, *Reconsideration of Audit Settlements.*
[2/1/95; 8.312.2.17 NMAC - Rn, 8 NMAC 4.MAD.731.8, 6/15/10; A, 7/1/12]

8.312.2.18 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) OF [~~MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS~~] ELIGIBLE RECIPIENTS WITH MENTAL ILLNESS OR INTELLECTUAL DISABILITIES (MENTAL RETARDATION): [~~As part of the initial abstract for a new admission and/or as part of a subsequent specified review as determined by PASRR or a significant change review as indicated by the minimum data set (MDS) for residents with identified mental illness or mental retardation, NFs must complete a level I pre-admission screening and resident review of mentally ill and mentally retarded (PASRR) screening. See Omnibus Reconciliation Acts of 1987 and 1990 as codified at 42 CFR Section 483.100 Subpart C. See also P.L. 104-315 which amends title XIX of the Social Security Act effective October 19, 1996. This requirement applies to all applicants or residents, regardless of payment source.~~] As part of the initial abstract for a new admission or as part of a subsequent specified review as determined by PASRR, or a

significant change review as indicated by the minimum data set (MDS) for an eligible recipient resident with identified mental illness or has intellectual disabilities, the NF must complete a level I PASRR screening. The NF must submit the initial abstract with any accompanying documentation and the PASRR level 1 screening document within seven calendar days of the eligible recipient's date of admission. See Omnibus Reconciliation Acts of 1987 and 1990 as codified at 42 CFR Section 483.100 Subpart C. See also P.L. 104-315 which amends title XIX of the Social Security Act effective October 19, 1996. This requirement applies to all applicants or residents, regardless of payment source.

A. Pre-admission screens not required: Pre-admission screens do not need to be performed on the following [~~residents~~] eligible recipient resident:

(1) [~~residents~~] when admitted from the hospital whose attending physicians certify before admission to the NF that the [~~residents are~~] eligible recipient resident is likely to require NF care for less than [~~thirty (30)~~] 30 days (as determined by PASRR review of the [~~individuals~~] his or her level I screen data prior to NF admission);

(2) [~~residents who are~~] when readmitted to NFs from hospitals to which [~~they were~~] he/she was transferred for the purpose of receiving care; and

(3) [~~residents who are~~] when transferred from one NF to another without an intervening hospital stay.

B. Purpose of the screens: The purpose of the PASRR screen is to determine whether residents have a mental illness or [~~mental retardation~~] intellectual disabilities, need the level of services furnished in a NF and need specialized services based on the mental illness or [~~mental retardation~~] intellectual disabilities. [~~NFs perform~~] A NF performs the level I screen which identifies [~~residents~~] an eligible recipient resident who [~~can have~~] has a mental illness or [~~mental retardation~~] intellectual disabilities. When [~~residents are~~] an eligible recipient resident is identified, the NF refers [~~them~~] him or her to the developmental disabilities division of [~~the department of health~~] DOH for a PASRR level II evaluation.

C. Level II screen determination: The PASRR level II screen determines the following:

(1) the eligible recipient resident's total needs are such that his or her needs can be met in an appropriate community setting;

(2) the eligible recipient resident's total needs are such that they can be met only on an inpatient basis, which can include the option of placement in a home and community-based service waiver program, but for which inpatient care is necessary;

(3) if inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs; or

(4) if inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the [~~individual's~~] eligible recipient resident's needs, another setting, such as an intermediate care facility for the mentally retarded can be indicated.

D. Right to an administrative hearing: Residents who believe that an erroneous determination was made with regard to the PASRR can request administrative hearings. See [~~Section MAD-990,~~] 8.354.2 NMAC, *PASRR and Patient Status Hearings*, for more information. The NF must [~~give residents~~] provide notice to an eligible recipient resident of proposed transfers or changes of status. The notice must inform [~~residents of their~~] an eligible recipient resident of his or her right to request a hearing, the method by which a hearing can be requested and [~~their~~] his or her right to present evidence in person or through representatives. [~~A resident~~] An eligible recipient resident who requests a hearing has [~~ninety (90)~~] 90 calendar days after the date of the notice to request a hearing. Within [~~sixty (60)~~] 60 days of receipt of the request for a hearing, the hearing is conducted, decisions reached and notice furnished to the eligible recipient resident and the NF.

E. Restriction on reimbursement for medicaid residents: [~~Nursing facilities are~~] A NF is not reimbursed for any service furnished to [~~medicaid recipients~~] an eligible recipient resident when pre-admission screens, subsequent specified reviews or significant change reviews are not performed in a timely manner. [~~Medicaid~~] MAD pays only for services furnished after the screens or reviews are performed and will recoup amounts paid to [~~NFs~~] a NF during periods of noncompliance. [~~Medicaid~~] MAD payment for services does not begin until a Level II screening has been performed, if applicable.

[2/1/95; 8.312.2.18 NMAC - Rn, 8 NMAC 4.MAD.731.9, 6/15/10; A, 7/1/12]

8.312.2.19 MINIMUM DATA SET:

A. [~~Long term care facilities~~] A long term care facility participating in the medicare and [~~medicaid~~] the MAD [~~programs are~~] program is required to conduct a comprehensive, accurate, standardized, reproducible assessment of each eligible recipient resident's functional capacity. See Sections 4201 (a)(3) and 4211 (a)(3) of the Omnibus Reconciliation Act (OBRA) of 1987.

B. The capacity assessment describes the resident's ability to perform daily life functions and any significant impairment in functional capacity. The assessment is based on a uniform minimum data set (MDS) of core elements and common definitions specified by the secretary of the federal health and human services department. [~~Effective October 1, 2010 nursing facilities are required to use a new iteration of the MDS 3.0. The new version includes a revised section Q designed to identify nursing facility residents who may be interested in moving back to the community. See Paragraph (9) of Subsection M of 8.307.1.7 NMAC, *money follows the person*.~~] A NF is required to use the most current iteration of the MDS. A section of the MDS requires a NF to identify eligible recipient residents who may be interested in transitioning back to his or her community. The NF is responsible for making this referral to the department of aging and long-term services or its successor. See Paragraph (9) of Subsection M of 8.307.1.7 NMAC, *money follows the person.*

(1) The resident assessment instrument (RAI) is specified by the state. State RAIs include at least the health care financing administration MDS, triggers, resident assessment protocols (RAPs) and utilization guidelines.

(2) On a date to be specified by the federal government, NFs will be required to encode the MDS in machine-readable form. After that date, all MDS reporting will be done [~~by computer~~] electronically.

[2/1/95; 8.312.2.19 NMAC - Rn, 8 NMAC 4.MAD.731.10, 6/15/10; A, 7/1/12]

8.312.2.20 MEDICAL CARE CREDITS: If [~~a~~] an eligible recipient resident has income beyond the maintenance allowance, MAD reimburses the NF for the difference between the NF's reimbursable rate and the medical care credit. The NF is responsible for collecting the amount reported as the medical care credit. These medical care credit requirements also apply to co-payments and deductibles for medicare crossover payments.

[2/1/95; 8.312.2.20 NMAC - Rn, 8 NMAC 4.MAD.731.11, 6/15/10; A, 7/1/12]

8.312.2.21 NURSE AIDE TRAINING: [~~Nursing facilities participating in medicaid agree to~~] A NF must comply with nurse aide training requirements as a condition of MAD participation. See 42 CFR Section 483 Subpart D. The NF [~~program is not~~] will not be approved if the NF has been out of compliance with [~~certain~~] federal requirements within the previous [~~two (2) years~~] 24 calendar months.

A. Requirements for nurse aide training: [~~NFs cannot employ individuals as nurse aides~~] A NF cannot employ individuals as nurse aides for more than four [~~(4)~~] months unless they have completed a nurse aide training and competency evaluation program (NATCEP). The NATCEP program must have a minimum duration of [~~seventy-five (75)~~] 75 hours.

(1) [~~Nurse aides who have~~] A nurse aide who has not performed nursing or nursing-related services for monetary compensation for a period of [~~twenty-four (24)~~] 24 consecutive months since completion of a NATCEP must take either a new NATCEP or a new competency evaluation program (CEP).

(2) [~~NFs~~] A NF must not use temporary nurse aides who have not completed a NATCEP or a CEP.

(3) [~~NFs~~] A NF must ensure that students in the NATCEP programs do not perform any services for which they have not been trained and found proficient by instructors. [~~NFs~~] A NF must ensure that all students in NATCEP programs are under the general supervision of licensed or registered nurses when they perform services for MAD eligible recipient residents.

(4) [~~NFs~~] A NF must furnish regular performance reviews and in-service education to ensure that individuals who serve as nurse aides are competent to perform nurse aide services.

B. Other nurse aide requirements: [~~NFs~~] A NF must not employ individuals who have been convicted by the court of abuse or neglect of any NF residents or misappropriation of any NF residents' property.

C. Nurse aide registry: [~~The licensing and certification bureau of the~~] DOH maintains a registry of all [~~individuals~~] nursing aides who have successfully completed, who have been considered to have completed a NATCEP or CEP program or who have had the NATCEP or CEP requirement waived by the state.

[2/1/95; 8.312.2.21 NMAC - Rn, 8 NMAC 4.MAD.731.12, 6/15/10; A, 7/1/12]

8.312.2.22 PATIENT SELF DETERMINATION ACT: All adult eligible recipient residents of nursing facilities must be informed of their right to make their own health decisions, including the right to accept or refuse medical treatment as specified in the Patient Self-Determination Act. [~~See Section MAD-701, General Provider Policies [8.302.1 NMAC, General Provider Policies].~~] See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.312.2.22 NMAC - Rn, 8 NMAC 4.MAD.731.13, 6/15/10; A, 7/1/12]

8.312.2.23 RESIDENT RIGHTS TO REQUEST AN ADMINISTRATIVE HEARING: [~~Residents who believe~~] A MAD eligible recipient resident who believes that the NF has erroneously determined that [~~they~~] he or she should be transferred or discharged can request [~~an~~] a HSD administrative hearing. [~~NFs must give residents~~] A

NF must provide an eligible recipient resident notice of the proposed transfer or discharge. The notice must inform [~~residents of their~~] the eligible recipient resident of his or her right to request a hearing, the method by which a hearing can be requested and [~~their~~] his or her right to present evidence in person or through his or her representatives. [~~See Section MAD-970, Recipient Hearings [8.352.2 NMAC, Recipient Hearings].~~] See 8.352.2 NMAC, *Recipient Hearings*.
[2/1/95; 8.312.2.23 NMAC - Rn, 8 NMAC 4.MAD.731.14, 6/15/10; A, 7/1/12]

8.312.2.24 PRIOR APPROVAL AND UTILIZATION REVIEW: [~~All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, Prior Approval and Utilization Review [8.302.5 NMAC, Prior Authorization and Utilization Review]. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.~~] All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Reviews can 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 Authorization and Utilization Review*. The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services.

A. Prior approval: Certain procedures or services 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. See Subsection A of 8.311.2.16 NMAC, *emergency room services*.

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.~~] Prior authorization of services does not guarantee that an individual is eligible for medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has 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 [8 NMAC 4.MAD.953.~~] A provider who disagrees with a prior approval request denial or other review decisions can request a reconsideration of utilization review. See 8.350.2 *Reconsideration of Utilization Review Decisions.*
[2/1/95; 8.312.2.24 NMAC - Rn, 8 NMAC 4.MAD.731.15, 6/15/10; A, 7/1/12]

8.312.2.25 REIMBURSEMENT: Nursing facility providers must submit claims for reimbursement on the [~~long-term care turn-around document (TAD) or its successor~~] uniform billing form. [~~See Section MAD-702, Billing for Medicaid Services [8.302.2 NMAC, Billing for Medicaid Services. Once enrolled, providers receive instructions on documentation, billing and claims processing.~~] See 8.302.2 NMAC, *Billing for Medicaid Services.*

A. MAD reimburses a NF at the lesser of the following:

(1) the [~~provider's~~] NF's billed charges;

(2) [~~See Section MAD-731-D, Cost Related Reimbursement of Nursing Facilities [8.312.3 NMAC, Cost Related Reimbursement of Nursing Facilities for prospective reimbursement rates constrained by the ceilings established by MAD.~~] the prospective reimbursement rates constrained by the ceilings established by MAD; see 8.312.3 NMAC, *Cost Related Reimbursement of Nursing Facilities*;

(3) the NF's billed charge must be their usual and customary charge for services; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

B. Reimbursement limitations: Payments are made only to [~~NFs~~] a NF which [~~meet~~] meets the conditions for participation, specified in this section. Payments to [~~NFs~~] a NF are limited to those service costs which are included as allowable costs under approved provisions of the state plan. [~~See Section MAD-731-D, Cost Related Reimbursement of Nursing Facilities [8.312.3 NMAC, Cost Related Reimbursement of Nursing Facilities.~~] See 8.312.3 NMAC, *Cost Related Reimbursement of Nursing Facilities*. All claims for payment from MAD are subject to utilization review and control.

C. Reimbursement methodology: [~~See Section MAD 731 D, Cost Related Reimbursement of Nursing Facilities [8.312.3 NMAC, Cost Related Reimbursement of Nursing Facilities.~~] See 8.312.3 NMAC, *Cost Related Reimbursement of Nursing Facilities.*
[2/1/95; 6/1/98; 8.312.2.25 NMAC - Rn, 8 NMAC 4.MAD.731.16, 6/15/10; A, 7/1/12]

HISTORY OF 8.312.2 NMAC:
Pre- NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.0300, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 2/27/80.
MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 12/1/87.
MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 1/6/88.
MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/92.
SP-004.1903, Section 4, General Program Administration Reserve Beds, filed 6/10/81.
SP-004.1101, Section 4, General Program Administration Standards for Institutions, filed 6/26/81.

History of Repealed Material:
MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/92 - Repealed effective 2/1/95.

TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 6 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.6.3 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 NMSA 1978, Sections 27-2-12 et seq.~~] The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.314.6.3 NMAC - Rp, 8.314.6.3 NMAC, 4-1-11; A, 7-1-12]

8.314.6.6 OBJECTIVE: [~~The objective of this rule is to provide rules for the service portion of the New Mexico medicaid program. This rule describes eligible providers, eligible participants, covered services, non-covered services, utilization review, and provider reimbursement.~~] The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.314.6.6 NMAC - Rp, 8.314.6.6 NMAC, 4-1-11; 7-1-12]

8.314.6.7 DEFINITIONS:

A. **AIDS waiver:** A [~~medicaid~~] medical assistance division (MAD) home and community-based services (HCBS) waiver program for eligible recipients who are diagnosed as having acquired immunodeficiency syndrome (AIDS) or AIDS-related conditions and who meet the level of care provided in a nursing facility (NF).

B. **Authorized agent:** The [~~participant~~] eligible recipient may choose to appoint an authorized agent designated to have access to medical and financial information for the purpose of offering support and assisting the [~~participant~~] eligible recipient in understanding waiver services. The [~~participant~~] eligible recipient will designate a person to act as an authorized agent by signing a release of information form indicating the [~~participant's~~] eligible recipient's consent to the release of confidential information. The authorized agent will not have the authority to direct mi via waiver services. Directing services remains the sole responsibility of the [~~participant~~] eligible recipient or his/her legal representative. The [~~participant's~~] eligible recipient's authorized agent does not need a legal relationship with the [~~participant~~] eligible recipient. While the [~~participant's~~] eligible recipient's authorized agent can be a service provider for the [~~participant~~] eligible recipient, the authorized agent cannot serve as the [~~participant's~~] eligible recipient's consultant. If the authorized agent is an employee, he/she cannot sign his/her own timesheet.

C. **Authorized annual budget (AAB):** [~~The actual amount of the annual budget approved for a participant by the TPA. Participants work with their consultant to develop an annual budget request, which is submitted to the TPA for review and approval. The total amount approved by the TPA is the authorized annual budget (AAB).~~] The eligible recipient works with his or her consultant to develop an annual budget request which is submitted to the third party assessor (TPA) for review and approval. The total annual amount of the mi via services and goods includes the frequency, the amount, and the duration of the waiver services and the cost of waiver goods approved by the TPA. Once approved, this is the annual approved budget (AAB).

D. **Brain injury (BI):** [~~Individuals~~] Eligible recipients (through age 65) with an injury to the brain of traumatic or acquired origin resulting in a total or partial functional disability or psychosocial impairment or both. The BI [~~participant~~] eligible recipient must have a documented BI diagnosis, as included in the international classification of diseases (ICD-9-CM or its successor).

E. **Category of eligibility (COE):** To qualify for [~~medicaid,~~] a medical assistance program, [~~a person~~] an applicant must meet financial criteria and belong to one of the groups that the state has defined as eligible. [~~All participants~~] An eligible recipient in mi via must belong to one of the categories of eligibility (COE) described in 8.314.6.13 NMAC.

F. **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~~] medical assistance programs operated under HSD.

G. **Consultant provider:** May be an agency or an individual. Provides consultant and support guide services to [~~mi via participants~~] the eligible recipient that assist the [~~participant~~] eligible recipient (or the [~~participant's~~] eligible recipient's family or legal representative, as appropriate) in arranging for, directing and managing mi via services and supports, as well as developing, implementing and monitoring the service and support plan (SSP) and AAB.

H. **Eligible recipient:** An applicant meeting the financial and medical LOC criteria who is approved to receive MAD services through the mi via program.

[~~H.~~] I. **Employer of record (EOR):** The employer of record (EOR) is the individual responsible for directing the work of mi via employees, including recruiting, hiring, managing and terminating all employees. The EOR tracks expenditures for employee payroll, goods, and services. EORs authorize the payment of timesheets by the financial management agency (FMA). [~~A participant~~] An eligible recipient may be his/her own EOR unless the [~~participant~~] eligible recipient is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. [~~Participants~~] An eligible recipient may also designate an individual of [~~their~~] his or her choice to serve as [~~their~~] the EOR, subject to the EOR meeting the qualifications specified in [~~these regulations~~] this rule.

[~~I.~~] J. **Financial management agency (FMA):** Contractor that helps implement the AAB by paying the [~~participant's~~] eligible recipient's service providers and tracking expenses.

[~~J.~~] K. **Home and community-based services (HCBS) waiver:** [~~Medicaid~~] A MAD program that provides alternatives to long-term care services in institutional settings. The federal government waives certain statutory requirements of the Social Security Act to allow states to provide an array of community-based options through these waiver programs.

[~~K.~~] L. **Individual budgetary allotment (IBA):** The maximum budget allotment available to an [~~individual participant~~] eligible recipient, determined by his/her established level of care (LOC) and category of eligibility. Based on this maximum amount, the [~~participant~~] eligible recipient will develop a plan to meet his/her assessed functional, medical and habilitative needs to enable the [~~participant~~] eligible recipient to remain in the community.

[~~L.~~] M. **Intermediate care facilities for the mentally retarded (ICF/MR):** Facilities that are licensed and certified by the New Mexico department of health (DOH) to provide room and board, continuous active treatment and other services for eligible [~~medicaid~~] MAD recipients with a primary diagnosis of [~~mental retardation~~] intellectually disabled.

[~~M.~~] N. **Legal representative:** A person that is a legal guardian, conservator, power of attorney or otherwise has a court established legal relationship with the [~~participant~~] eligible recipient. The [~~participant~~] eligible recipient must provide certified documentation to the consultant provider and FMA of the legal status of the representative and such documentation will become part of the [~~participant's~~] eligible recipient's file. The legal representative will have access to [~~participant~~] the eligible recipient's medical and financial information to the extent authorized in the official court documents.

[~~N.~~] O. **Legally responsible individual (LRI):** A legally responsible individual (LRI) is any person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal, or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or a spouse.

[~~O.~~] P. **Level of care (LOC):** The level of care (LOC) required by an [~~individual~~] eligible recipient in an institution. [~~Participants~~] An eligible recipient in the mi via program must be determined to need either the LOC required for admittance to a licensed nursing facility (NF) or an ICF/MR.

[~~P.~~] Q. **Mi via:** Mi via is the name of the Section 1915 (c) [~~medicaid~~] MAD self-directed HCBS waiver program through which [~~eligible participant~~] an eligible recipient [~~have~~] has the option to access services to allow [~~them~~] him or her to remain in the community.

R. **Money follows the person (MFP):** MFP is a demonstration grant administered by CMS. During the grant period, grantee states use available funding to facilitate transitions from qualified institutions to qualified community settings that are covered under CoLTS when New Mexico has been authorized by CMS as a grantee state and when the state exercises the option to utilize the grant. MFP participants must meet specific CMS criteria referenced in the CMS grant terms and conditions and the CMS approved state MFP operational protocol (OP). The definition for qualified eligible individuals, institutions and community settings are detailed in the OP. The MCO may assess the use of MFP grant demonstration, supplemental or MCO enhanced or value added transition goods and services when an eligible recipient in coordination with the CoLTS 1915 (c) HCBS transition goods and services.

[~~R. **Participant:** Individuals meeting the financial and medical LOC criteria who are approved to receive services through the mi via program.~~]

S. **Reconsideration:** [~~Participants who disagree~~] An eligible recipient who disagrees with a clinical/medical utilization review decision or action may submit a written request [~~through a consultant~~] to the [~~third party assessor (TPA)~~] TPA for a reconsideration of the decision. The eligible recipient may submit the request for a reconsideration through the consultant or the consultant agency or may submit the request directly to MAD.

T. **Self-direction:** [~~Process applied to the service delivery system wherein participants identify access and manage the services they obtain (among the state-determined waiver services and goods) to meet their~~

~~personal assistance and other health-related needs.~~] The process applied to the service delivery system wherein the eligible recipient identifies, accesses and manages the services (among the state-determined waiver services and goods) that meet his or her assessed therapeutic, rehabilitative, habilitative, health or safety needs to support the eligible recipient to remain in his or her community.

U. **Service and support plan (SSP):** [~~Participant plan that includes waiver services that meet the participant's needs to needs to include the projected amount, frequency and duration of the services; the type of provider who will furnish each service; other services that the participant will access; and the participant's the available supports that will complement waiver services in meeting his/her needs.~~] A plan that includes waiver services that meet the eligible recipient's needs include: the projected amount, the frequency and the duration of the waiver services; the type of provider who will furnish each waiver service; other services the eligible recipient will access; and the eligible recipient's available supports that will compliment waiver services in meeting his or her needs.

[~~U. **State or state agency:** The mi via waiver program is managed and administered by two state agencies, the department of health (DOH), and the human services department, medical assistance division (HSD/MAD). References to the "state" or "state agency" means these two agencies or other specifically indicated agency as appropriate.~~]

V. **Support guide:** A function of the consultant provider that directly assists the [~~participant~~] the eligible recipient in implementing the SSP to ensure access to mi via services and supports and to enhance success with self-direction. Support guide services provide assistance to the [~~participant~~] the eligible recipient with employer/vendor functions or with other aspects of implementing his/her SSP.

W. **Third-party assessor (TPA):** The contractor that determines and re-determines LOC and medical eligibility for mi via services. The TPA also reviews each [~~participant's~~] the eligible recipient's SSP and approves an AAB for each [~~participant~~] the eligible recipient. The TPA performs utilization management duties of all waiver services.

X. **Waiver:** A program in which the federal government has waived certain statutory requirements of the Social Security Act to allow states to provide an array of home and community-based service options through [~~medicaid~~] MAD as an alternative to providing long-term care services in an institutional setting.

[8.314.6.7 NMAC - N, 4-1-11; A, 4-1-12; A, 7-1-12]

8.314.6.9 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER:

A. [~~Mi via,~~] New Mexico's self-directed waiver program [~~(mi via),~~] known as mi via is intended to provide a community-based alternative to institutional care that allows [~~eligible participant~~] an eligible recipient to have control over services and supports. Mi via provides self-directed home and community-based services to eligible recipients[~~, hereafter referred to as participants,~~] who are living with disabilities [~~(CoLTS (c))~~], conditions associated with aging [~~(CoLTS (c))~~], certain traumatic or acquired brain injuries (BI), acquired immunodeficiency syndrome (AIDS), developmental disabilities (DD), or medically fragile conditions (MF). (See 42 CFR 441.300.)

B. Mi via is comprised of two [~~medicaid~~] MAD home and community-based waivers established under Section 1915(c) of the Social Security Act. One waiver is specifically for eligible [~~individuals~~] recipients who meet the LOC otherwise provided in a nursing facility (NF). The second waiver is specifically for eligible [~~individuals~~] recipients who meet the LOC otherwise provided in an ICF/MR. [~~Both waivers are managed as a single self-directed program and are administered collaboratively by the DOH and HSD/MAD.~~]

(1) Both waivers are managed as a single self-directed program and are administered collaboratively by the DOH and HSD/MAD. [~~The HSD/MAD~~] MAD is responsible for the daily administration of mi via for eligible [~~individuals~~] recipients living with disabilities, conditions associated with aging, and certain traumatic or acquired brain injuries who meet the LOC for admittance to an NF. [~~The~~] DOH is responsible for the daily administration of mi via for eligible [~~individuals~~] recipients living with developmental disabilities and medically fragile conditions who meet the LOC for admittance to an ICF/MR The DOH also manages the waiver for [~~individuals~~] eligible recipients living with AIDS who meet the LOC for admittance to an NF.

(2) Enrollment in mi via is limited to the number of federally authorized unduplicated [~~participants~~] eligible recipients and funding appropriated by the New Mexico legislature for this purpose.

[8.314.6.9 NMAC - Rp, 8.314.6.9 NMAC, 4-1-11; A, 4-1-12; A, 7-1-12]

8.314.6.10 MI VIA CONTRACTED ENTITIES AND PROVIDERS SUPPORTING SELF-DIRECTED SERVICES: The following resources and services have been established to assist [~~participants~~] eligible recipients to self-direct services. These include the following.

A. **Consultant services:** Consultant services are direct services intended to educate, guide and assist the [~~participant~~] eligible recipient to make informed planning decisions about services and supports, to develop a service and support plan (SSP) that is based on the [~~participant's~~] eligible recipient's assessed disability-related needs and to assist the [~~participant~~] eligible recipient with quality assurance related to the SSP and AAB.

B. **Third-party assessor:** The TPA or [~~HSD/MAD's~~] MAD's designee is responsible for determining medical eligibility through an LOC assessment, assigning the applicable individual budgetary allotment (IBA), approving the SSP and authorizing [~~a participant's~~] an eligible recipient's annual budget in accordance with mi via [~~regulations~~] rules and service standards. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.6.13 NMAC; LOC determinations are done initially for [~~individuals~~] eligible recipients who are newly [~~allocated~~] enrolled to the mi via waiver and thereafter at least annually for currently enrolled mi via [~~participants~~] eligible recipients; the LOC assessment is done in person with the [~~participant~~] eligible recipient in his/her home, an agreed upon location or in an inpatient setting; the TPA may re-evaluate the LOC more often than annually if there is an indication that the [~~participant's~~] eligible recipient's condition or LOC has changed;

(2) applies the information from the LOC documentation and the following assessments, long-term care assessment abstract (NF or ICF/MR), the comprehensive individual assessment (CIA), the universal assessment tool (UAT), or other state approved assessment tools, as appropriate for the category of eligibility, to assign the IBA for [~~participants~~] the eligible recipients that are medically eligible; and

(3) reviews and approves the SSP and the annual budget request resulting in an AAB, at least annually or more often if there is a change in the [~~participant's~~] eligible recipient's circumstances in accordance with mi via [~~regulations~~] rules and service standards.

C. **Financial management agent (FMA):** The FMA acts as the intermediary between the [~~participant~~] eligible recipient and the [~~medicaid~~] MAD payment system and assists the [~~participant~~] eligible recipient or the EOR with employer-related responsibilities. The FMA pays employees and vendors based upon an approved SSP and AAB. The FMA assures [~~participant~~] the eligible recipient and program compliance with state and federal employment requirements, monitors, and makes available to [~~participants~~] the eligible recipients and [~~the state~~] reports related to utilization of services and budget expenditures. Based on the [~~mi via participant's~~] eligible recipient's [~~individual~~] approved individual SSP and AAB, the FMA must:

(1) verify that [~~mi via participants~~] the recipients are eligible for [~~medicaid~~] MAD services prior to making payment for services;

(2) receive and verify that all required employee and vendor documentation and qualifications are in compliance with the mi via [~~regulations~~] rules and service standards;

(3) establish an accounting for each [~~participant's~~] eligible recipient's AAB;

(4) process and pay invoices for goods, services, and supports approved in the SSP and the AAB and supported by required documentation;

(5) process all payroll functions on behalf of [~~participants~~] the eligible recipients and EORs including:

(a) collect and process timesheets of employees;

(b) process payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance; and

(c) track and report disbursements and balances of the [~~participant's~~] eligible recipient's AAB and provide a monthly report of expenditures and budget status to the [~~participant~~] eligible recipient and his/her consultant, and quarterly and annual documentation of expenditures to [~~the state~~] MAD;

(6) receive and verify provider agreements, including collecting required provider qualifications;

(7) monitor hours billed for services provided by the LRI and the total amounts billed for all goods and services during the month;

(8) answer inquiries from [~~participants~~] the eligible recipients and solve problems related to the FMA's responsibilities; and

(9) report any concerns related to the health and safety of [~~a participant's~~] the eligible recipient's or that the [~~participant~~] eligible recipient is not following the approved SSP and AAB to the consultant provider, [~~HSD/MAD~~] MAD and DOH, as appropriate.

[8.314.6.10 NMAC - Rp, 8.314.6.10 NMAC, 4-1-11; A, 4-1-12; A, 7-1-12]

8.314.6.11 QUALIFICATIONS FOR ELIGIBLE INDIVIDUAL EMPLOYEES, INDEPENDENT PROVIDERS, PROVIDER AGENCIES, AND VENDORS:

A. **Requirements for individual employees, independent providers, provider agencies and vendors:** In order to be approved as an individual employee, an independent provider, including non-licensed homemaker/companion workers, a provider agency (excluding consultant providers which are covered in a different subsection) or a vendor, including those that provide professional services, each entity must meet the general and service specific qualifications set forth in [~~these regulations~~] this rule and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. In order to be an authorized provider for mi via and receive payment for delivered services, the provider must complete and sign an employee or vendor provider agreement and all required tax documents. The provider must have credentials verified by the [~~participant/EOR~~] eligible recipient or the EOR and the FMA. In order to be an authorized consultant provider for the mi via program, the provider must have [~~an~~] approved provider [~~agreement~~] agreements executed by the DOH/developmental disabilities supports division (DDSD) and [~~HSD/MAD~~] MAD.

B. **General qualifications:**

(1) Individual employees, independent providers, including non-licensed homemaker/companion workers and provider agencies (excluding consultant providers) who are employed by a mi via [~~participant~~] eligible recipient to provide direct services shall:

(a) be at least 18 years of age;

(b) be qualified to perform the service and demonstrate capacity to perform required tasks;

(c) be able to communicate successfully with the [~~participant~~] eligible recipient;

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

(e) complete training on critical incident, abuse, neglect, and exploitation reporting;

(f) complete [~~participant specific training; the evaluation~~] training specific to the eligible recipient's needs. An assessment of training needs is determined by the [~~participant~~] eligible recipient or his/her legal representative; [~~the participant~~] the eligible recipient 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 [~~mi via participant's~~] eligible recipient's AAB; and

(g) meet any other service specific qualifications, as specified in [~~these regulations~~] this rule and service standards.

(2) Vendors, including those providing professional services[~~, shall~~]:

(a) shall be qualified to provide the service;

(b) shall possess a valid business license, if applicable;

(c) [~~if a professional provider, be~~] if professional providers, required to follow the applicable licensing regulations set forth by the profession; refer to the appropriate New Mexico board of licensure for information regarding applicable licenses;

(d) [~~if a consultant provider,~~] if consultant providers, meet all of the qualifications set forth in 8.314.6.11 NMAC;

(e) [~~if a currently approved waiver provider,~~] if currently approved waiver providers, are to be in good standing with the appropriate state agency; and

(f) meet any other service specific qualifications, as specified in the mi via [~~regulations~~] rules.

(3) [~~Relatives/legal representatives~~] Relatives or legal representatives, except LRIs (e.g., parents of minor children or spouses) may be hired and paid for provision of waiver services (except consultant/support guide, assisted living, and customized community supports services); payment is made to [~~a participant's~~] the eligible recipient's relative or legal representative for services provided when the relative/legal representative is qualified and approved to provide the service; the services must be identified in the approved SSP and AAB, and the [~~participant~~] eligible recipient or his/her legal representative is responsible for verifying that services have been rendered by completing, signing and submitting documentation, including the timesheet, to the FMA; relatives/legal representatives must provide services within the limits of the approved SSP and AAB and may not be paid in excess of 40 hours in a consecutive seven-day period; LRIs, legal representatives or relatives may not be both a paid employee for [~~a participant~~] the eligible recipient and serve as his/her EOR.

(4) [~~LRIs~~] Individuals with legal responsibility to provide care (LRI), e.g., the parent (biological, legal or adoptive) of a minor child (under age 18) [~~or the guardian of a minor child, who must provide care to the child,~~] or a spouse of [~~a mi via participant~~] the eligible recipient, may be hired and paid for provision of waiver services (except consultant/support guide, assisted living, and customized community supports services) under extraordinary circumstances in order to assure the health and welfare of the [~~participant~~] eligible recipient, to avoid

institutionalization when approved by MAD and provided that [~~the state~~] MAD is eligible to receive federal financial participation (FFP).

(a) Extraordinary circumstances include the inability of the LRI to find other qualified, suitable caregivers when the LRI would otherwise be absent from the home and, thus, the caregiver must stay at home to ensure the [~~participant's~~] eligible recipient's health and safety.

(b) 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.

(c) Services provided by LRIs must:

(i) meet the definition of a service or support and be specified in the [~~participant's~~] eligible recipient's approved SSP and AAB;

(ii) be provided by a parent or spouse who meets the provider qualifications and training standards specified in the waiver and his rule for that service; and

(iii) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service, and be approved by the TPA.

(d) An LRI who is a service provider must comply with the following:

(i) a parent, parents in combination, or a spouse, may not provide more than 40 hours of services in a consecutive seven-day period; for parents of the eligible recipient, 40 hours is the total amount of service regardless of the number of [~~children~~] eligible recipients under the age of 21who receive services [~~under~~] through the mi via waiver;

(ii) planned work schedules must be identified in the approved SSP and AAB, and variations to the schedule must be reported to the [~~participant's~~] eligible recipient's consultant and noted and supplied to the FMA when billing; and

(iii) timesheets and other required documentation must be maintained and submitted to the FMA for hours paid.

(e) [~~Married individuals must be offered a choice of providers. If they choose a spouse as their service provider and it is approved in writing by HSD/MAD or DOH, it must be documented in the SSP.~~] An eligible recipient must be offered a choice of providers. There must be written approval from MAD when an eligible CoLTS (c) or BI recipient, or from DOH when an eligible DOH AIDS, DD or MF recipient chooses his or her spouse as a provider. This written approval must be documented in the SSP.

(f) [~~Children~~] Eligible recipients 16 years of age or older must be offered a choice of provider. [~~If a child chooses his or her parent and it is approved in writing by HSD/MAD or DOH, it must be documented in the SSP.~~] There must be written approval from MAD when an eligible CoLTS (c) or BI recipient or from DOH when an eligible DOH AIDS, DD and MF recipient chooses his or her parent as a provider. This written approval must be documented in the SSP.

(g) The FMA monitors, on a monthly basis, hours billed for services provided by the LRI and the total amounts billed for all goods and services during the month.

[~~(h) Hiring of LRIs must be approved in writing by HSD/MAD for CoLTS (c) and BI populations, or DOH for the AIDS, DD and MF populations.~~]

(5) Once enrolled, providers, vendors and contractors receive a packet of information from the [~~mi via participant~~] eligible recipient or FMA, including [~~medicaid~~] billing instructions, and other pertinent materials. Mi via [~~participants~~] eligible recipients or legal representatives are responsible for ensuring that providers, vendors and contractors have received these materials and for updating them as new materials are received from the state ([~~HSD/MAD~~] MAD for CoLTS (c), and BI or DOH for AIDS, DD, and MF). MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, an eligible recipient or legal representative, or provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or legal representative, or provider, vendor, or contractor to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The eligible recipient or legal representative, or provider, vendor, or contractor must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials.

(a) No provider of any type may be paid in excess of 40 hours within the established work week for any one [~~participant~~] eligible recipient or EOR.

(b) No provider agency is permitted to perform both LOC assessments and provide any services for [~~mi via participants~~] the eligible recipients.

(c) [~~Mi via providers~~] Providers may market their services, but are prohibited from soliciting [~~participants~~] eligible recipients under any circumstances.

(6) [~~Employer of record.~~] The EOR is the individual responsible for directing the work of the eligible recipient's employees. [~~Mi Via~~] MAD encourages [~~the participant~~] an eligible recipient 18 years of age or older to be [~~the~~] his or her own EOR. It is also possible to designate someone else to act as the EOR.

(a) [~~If a participant~~] An eligible recipient that is the subject of a plenary or limited guardianship or [~~conservator~~] conservatorship [~~regarding financial matters, he/she~~] may not be his or her own EOR.

(b) A person under the age of 18 years may not be an EOR.

(c) An EOR who lives outside New Mexico shall reside within 100 miles of the New Mexico state border. If the [~~participant~~] eligible recipient wants to have an EOR who resides beyond this radius, [~~he/she~~] the eligible recipient must obtain written approval from [~~appropriate state program manager prior to the EOR performing any duties.~~] MAD (when an eligible CoLTS (c) or BI recipient) or from DOH (when an eligible DOH AIDS, DD or MF recipient) prior to the EOR performing any duties. This written approval must be documented in the SSP.

(d) [~~A participant's~~] The eligible recipient's provider may not also be his/her EOR.

(e) An EOR whose performance compromises the health, safety or welfare of the [~~participant~~] eligible recipient, may have his/her status as an EOR terminated.

(f) An EOR may not be paid for any other services [~~provided to~~] utilized by the [~~participant~~] eligible recipient for whom [~~they are~~] he or she is the EOR, whether as an employee of the [~~participant~~] eligible recipient, a vendor, or an employee or contactor of an agency. An EOR makes important determinations about what is in the best interest of [~~a participant~~] the eligible recipient, and should not have any conflict of interest. An EOR assists in the management of the [~~participant's~~] eligible recipient's budget and should have no personal benefit connected to the services requested or approved on the budget.

C. **Service specific qualifications for consultant services providers:** [~~Consultant providers shall ensure that all individuals providing consultant meet the criteria specified in this section in addition to the general requirements.~~] In addition to general requirements, a consultant provider shall ensure that all individuals hired or contracted consultant services meet the criteria specified in this section in addition to as well to perform all applicable rules and service standards.

(1) Consultant providers shall:

(a) possess a minimum of a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field, and have one year of supervised experience working with [~~seniors~~] the elderly or people living with disabilities; or

(b) have a minimum of six years of direct experience related to the delivery of social services to [~~seniors~~] the elderly or people living with disabilities, and be employed by an enrolled mi via consultant provider agency; and

(c) complete all required mi via orientation and training courses.

(2) Consultant providers may also use non-professional staff to carry out support guide functions. Support guides provide more intensive supports, as detailed in the service section of these rules. Support guides help the [~~participant~~] eligible recipient more effectively self-direct services when there is an identified need for this type of assistance. Consultant providers shall ensure that non-professional support staff:

(a) are supervised by a qualified consultant as specified in this regulation;

(b) have experience working with seniors or people living with disabilities;

(c) demonstrate the capacity to meet the [~~participant's~~] eligible recipient's assessed needs related to the implementation of the SSP;

(d) possess knowledge of local resources, community events, formal and informal community organizations and networks;

(e) are able to accommodate a varied, flexible and on-call type of work schedule in order to meet the needs of [~~participant~~] the eligible recipient; and

(f) complete training on self-direction and incident reporting.

D. **Service specific qualifications for personal plan facilitation providers:** [~~A~~] In addition to general requirements, a personal plan facilitator agency must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Personal plan facilitators must possess the following qualifications in addition to the general qualifications:

(1) have at least one year of experience working with persons with disabilities; and

(2) be trained and certified in the planning tool(s) used; and

(3) have at least one year experience in providing the personal plan facilitation service.

E. **Service specific qualification for living supports providers:** [~~In addition to the general qualifications,~~] In addition to general requirements, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) **Qualifications of homemaker/direct support service providers:** Homemaker agencies must be certified by the [~~HSD/MAD~~] MAD or its designee. Home health agencies must hold a New Mexico home health agency license. Homemaker/home health agencies must hold a current business license when applicable, and meet financial solvency, training, records management, and quality assurance rules and requirements.

(2) **Qualifications of home health aide service providers:** Home health agency/homemaker agencies must hold a New Mexico current home health agency, rural health clinic, or federally qualified health center license. Home health aides must have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program pursuant to 7.28.2.30 NMAC. Home health aides must also be supervised by a registered nurse licensed in New Mexico. Such supervision must occur at least once every 60 calendar days in the [~~participant's~~] eligible recipient's home, and shall be in accordance with the New Mexico Nurse Practice Act and be specific to the [~~participant's~~] eligible recipient's SSP.

(3) **Qualifications of assisted living providers:** Assisted living providers must be licensed as an adult residential care facility by DOH pursuant to 7.8.2 NMAC, and meet all the requirements and regulations set forth by DOH as an adult residential care facility pursuant to 7.8.2 NMAC et seq.

(4) **Qualifications of customized in-home living supports providers:** The individual customized living provider must have at least one year of experience working with people with disabilities. Provider agencies must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Customized living agency staff must have one year of experience working with people with disabilities.

F. **Service specific qualifications for community membership support providers:** [~~In addition to the general qualifications~~] In addition to general requirements, the following types of providers must meet additional qualifications specific to the type of services provided. Community access provider agencies providing community direct support services must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements.

(1) **Qualifications of supported employment providers:**

(a) Job developers must have experience as a job developer for at least one year; have experience for at least one year developing and using job and task analyses; have experience for at least one year working with the division of vocational rehabilitation (DVR), a traditional DD waiver employment provider, an independent living center or other organization that provides employment supports or services for people with disabilities; and be trained on the purposes, functions and general practices of entities such as the department of workforce solutions navigators, one-stop career centers, business leadership network, chamber of commerce, job accommodation network, small business development centers, retired executives and New Mexico employment institute.

(b) Job coaches must have experience as a job coach for at least one year in the state of New Mexico; have experience for at least one year using job and task analyses; be trained on the Americans with Disabilities Act (ADA); and be trained on the purpose, function and general practices of the DVR office.

(2) **Qualifications of customized community supports providers:** Adult habilitation agency staff must have at least one year of experience working with individuals with disabilities. Adult day health provider agencies must be licensed by DOH as an adult day care facility pursuant to 7.13.2 NMAC. Adult day health agency staff must have at least one year of experience working with individuals with disabilities.

G. **Service specific qualifications for providers of health and wellness supports:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) **Qualifications of extended state plan skilled therapy providers for adults:** Physical and occupational therapists, speech/language pathologists, and physical therapy assistants must possess a therapy license in their respective field from the New Mexico regulation and licensing department (RLD). Certified occupational therapy assistants must possess an occupational therapy assistant certification from the New Mexico RLD. Speech clinical fellows must possess a clinical fellow license from the New Mexico RLD.

(2) **Qualifications of behavior support consultation providers:** Behavior consultant provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior consultant provider agencies shall comply with all applicable federal, state, and waiver [~~regulations, policies~~] rules and procedures regarding behavior consultation. Providers of behavior support consultation services must possess

qualifications in at least one of the following areas: licensed psychiatrist, licensed clinical psychologist, licensed psychologist associate, (masters or Ph.D. level), licensed independent social worker (LISW), licensed master social worker (LMSW), licensed professional clinical counselor (LPCC), licensed professional counselor (LPC), licensed psychiatric nurse (MSN/RNCS), licensed marriage and family therapist (LMFT), or licensed practicing art therapist (LPAT). Providers of behavior support consultation must maintain a current New Mexico license with the appropriate professional field licensing body.

(3) **Qualifications of nutritional counseling providers:** Nutritional counseling providers must maintain a current registration as dietitians by the commission on dietetic registration of the American dietetic association.

(4) **Qualifications of private duty nursing providers for adults:** Direct nursing services are provided by individuals who are currently licensed as registered or practical nurses by the New Mexico state board of nursing.

(5) Q**ualifications of specialized therapy providers:** Specialized therapy providers must possess a current New Mexico state license, as applicable, in at least one of the following areas:

(a) acupuncture and oriental medicine;

(b) biofeedback or a health care profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision;

(c) chiropractic medicine;

(d) cognitive rehabilitation therapy or a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision;

(e) hippotherapy or a health care profession whose scope of practice includes hippotherapy, and appropriate specialized training and experience;

(f) massage therapy;

(g) naprapathic medicine;

(h) play therapy or a [~~mental~~] behavioral health profession whose scope of practice includes play therapy, a master's degree or higher [~~mental~~] behavioral health degree, and specialized play therapy training and clinical experience and supervision; or

(i) Native American healers are individuals who are recognized as traditional healers within their communities.

H. **Service specific qualifications for other supports providers:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) **Qualifications of transportation providers:** Individual transportation providers must possess a valid New Mexico driver's license with the appropriate classification, be free of physical or mental impairment that would adversely affect driving performance, have no driving while intoxicated (DWI) convictions or chargeable (at fault) accidents within the previous two years, have current CPR/first aid certification; and be trained on DOH/division of health improvement (DHI) critical incident reporting procedures and have a current insurance policy and vehicle registration. Transportation vendors must hold a current business license and tax identification number. Each agency will ensure drivers meet the following qualifications:

(a) possess a valid, appropriate New Mexico driver's license;

(b) be free of physical or mental impairment that would adversely affect driving performance;

(c) have no DWI convictions or chargeable (at fault) accidents within the previous [~~two years~~] 24 months;

(d) have current CPR/first aid certification;

(e) be trained on DOH/DHI critical incident reporting procedures;

(f) have a current insurance policy and vehicle registration; and

(g) each agency will ensure vehicles have a current basic first aid kit in the vehicle.

(2) Q**ualifications of emergency response providers:** Emergency response providers must comply with all laws, rules and regulations of the New Mexico state corporation commission for telecommunications and security systems.

(3) **Qualifications of respite providers:** Respite services may be provided by eligible individual respite providers; licensed registered (RN) or practical nurses (LPN); or respite provider agencies. Individual RN/LPN providers must be licensed by the New Mexico state board of nursing as an RN or LPN. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements.

(4) **Qualifications of related goods vendors:** Related goods vendors must hold a current business license for the locale they are in and a tax ID for the state and federal government.

(5) **Qualifications of environmental modifications providers:** Environmental modification providers must possess an appropriate plumbing, electrician, contractor or other appropriate license.

[8.314.6.11 NMAC - Rp, 8.314.6.11 NMAC, 4-1-11; A, 4-1-12; A, 7-1-12]

8.314.6.12 RECORDKEEPING AND DOCUMENTATION RESPONSIBILITIES: Service providers and vendors who furnish goods and services to mi via [~~participants~~] eligible recipients are reimbursed by the FMA and must comply with all applicable MAD mi via [~~regulations~~] rules and service standards. The FMA, consultants and service providers must maintain records, which are sufficient to fully disclose the extent and nature of the goods and services provided to [~~participants~~] the eligible recipients, pursuant to 8.302.1.17 NMAC, *record keeping and documentation requirements,* and comply with random and targeted audits conducted by [~~HSD/MAD~~] MAD and DOH or their audit agents. [~~HSD/MAD~~] MAD or its designee will seek recoupment of funds from service providers when audits show inappropriate billing for services. Mi via vendors who furnish goods and services to mi via [~~participants~~] eligible recipients and bill the FMA must comply with all [~~medicaid~~] MAD provider participation agreement and MAD rules and requirements, including but not limited to 8.302.1 NMAC, *General Provider Policies*.

[8.314.6.12 NMAC - Rp, 8.314.6.12 NMAC, 4-1-11; A, 4-1-12; A, 7-1-12]

8.314.6.13 ELIGIBILITY REQUIREMENTS FOR [~~PARTICIPANT~~] RECIPIENT ENROLLMENT IN MI VIA: Enrollment in mi via is contingent upon the applicant meeting the eligibility requirements as described in the mi via [~~regulations~~] rules, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated [~~participants~~] eligible recipients. When sufficient funding as well as waiver positions are available, the appropriate state administering agency will offer the opportunity to [~~individuals~~] eligible recipients to apply for mi via. Once an allocation has been offered to the applicant, he/she must meet certain medical and financial criteria in order to qualify for mi via enrollment. [~~Applicants~~] Eligible recipients must meet the following eligibility criteria: financial eligibility criteria determined in accordance with 8.290.500 NMAC, and the [~~participant~~] eligible recipient must meet the LOC required for admittance to an NF or an ICF/MR and additional specific criteria as specified in the categories below.

A. **Developmental disability:** [~~Individuals~~] Eligible recipients who have a severe chronic disability, other than mental illness, that:

(1) is attributable to [~~a mental~~] intellectual disabilities or physical impairment, including the result of trauma to the brain, or a combination of [~~mental~~] intellectual disabilities and physical impairments;

(2) is manifested before the person reaches the age of 22 years;

(3) is expected to continue indefinitely;

(4) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency;

(5) reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other supports and services that are of life-long or extended duration and are individually planned and coordinated;

(6) the [~~individual~~] eligible recipient must have a developmental disability and [~~mental retardation~~] intellectual disability or a specific related condition; related conditions [~~are limited to cerebral palsy, autism (including asperger syndrome), seizure disorder, chromosomal disorders (e.g. down), syndrome disorders, inborn errors of metabolism, and developmental disorders of brain formation~~] as determined by the DOH/developmental disabilities support division (DDSD); and

(7) the [~~individual~~] eligible recipient must require an ICF/MR LOC.

B. **Medically fragile:** [~~Individuals~~] Eligible recipients who have been diagnosed with a medically fragile condition before reaching age 22, and who:

(1) have a developmental disability or developmental delay, or who are at risk for developmental delay; and

(2) have a chronic physical condition which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:

(a) have a life-threatening condition, characterized by reasonably frequent periods of acute exacerbation, which requires frequent medical supervision or physician consultation, and which, in the absence of

such supervision or consultation, would require hospitalization; or have frequent, time-consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen; and

(b) require ICF/MR LOC.

C. **Disabled and elderly:** [~~Individuals~~] Eligible recipients who are elderly (age 65 or older), blind or disabled, as determined by the MAD disability determination unit utilizing social security disability guidelines, who require NF LOC and either reside in the community, are institutionalized, or are at risk of institutionalization.

D. **AIDS:** [~~Individuals~~] Eligible recipients who have been diagnosed as having AIDS or AIDS-related condition (ARC) and who require NF LOC.

E. **Brain-injury (BI):** [~~Individuals (through age 64) with an injury to the brain of traumatic or acquired origin resulting in total or partial functional disability or psychosocial impairment or both.~~] Eligible recipients through age 65 with an injury to the brain of traumatic or acquired origin resulting in total or partial functional disability or psychosocial impairment or both. The BI eligible recipient must have a documented BI diagnosis, as included in the international classification of diseases (ICD-9-CM or its successor). The MAD usage of brain injury does not apply to brain injuries that are congenital, degenerative, induced by birth trauma or neurological disorders related to the aging process, or chemically caused brain injuries that are a result of habitual substance abuse. Additional criteria include:

(1) the term applies to open and closed head injuries caused by an insult to the brain from an outside physical force, anoxia, electrical shock, shaken baby syndrome, toxic and chemical substances, near-drowning, infections, tumors, or vascular lesions;

(2) BI may result in either temporary or permanent, partial or total impairments in one or more areas including, but not limited to: cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem solving, sensory perceptual and motor abilities, psychosocial behavior, physical functions, information processing and speech; and

[~~(3) the term **"*brain injury*"** does not apply to brain injuries that are congenital, degenerative, induced by birth trauma or neurological disorders related to the aging process, or chemically caused brain injuries that are a result of habitual substance abuse; the BI participant must have a documented BI diagnosis contained in the ICD-9-CM or its successor; and~~

~~(4)~~] (3) the individual must require NF LOC.

F. After initial eligibility has been established for a recipient, on-going eligibility must be re-determined on an annual basis.

[8.314.6.13 NMAC -Rp, 8.314.6.13 NMAC, 4-1-11; A, 4-1-12; A, 7-1-12]

8.314.6.14 [~~PARTICIPANT~~] ELIGIBLE RECIPIENT AND EOR RESPONSIBILITIES: Mi via [~~participants~~] eligible recipients have certain responsibilities to participate in the waiver. Failure to comply with these responsibilities or other program rules and [~~regulations~~] service standards can result in termination from the program. The [~~participant~~] eligible recipient and EOR have the following responsibilities:

A. To maintain eligibility [~~a participant~~] the eligible recipient must complete required documentation demonstrating medical and financial eligibility both upon application and annually at recertification, meet in person with the TPA for a comprehensive LOC assessment in the [~~applicant/[participant's~~] eligible recipient's home, an agreed upon location or an inpatient setting, and seek assistance with the application and the recertification process as needed from a mi via consultant.

B. To participate in mi via, [~~a participant~~] the eligible recipient must:

(1) comply with the rules and regulations that govern the program;

(2) collaborate with the consultant to determine support needs related to the activities of self-direction;

(3) collaborate with the consultant to develop an SSP using the IBA in accordance with mi via program [~~regulations~~] rules and service standards;

(4) use state funds appropriately by only requesting and purchasing goods and services covered by the mi via program in accordance with program [~~regulations and~~] rules which are identified [~~on~~] in the eligible recipient's approved SSP;

(5) comply with the approved SSP and not exceed the AAB;

(a) if [~~a participant~~] the eligible recipient does not adequately allocate the resources contained in the AAB resulting in a premature depletion of the AAB amount during an SSP year due to mismanagement or failure to properly track expenditures, the failure to properly allocate does not substantiate a claim for a budget

increase (i.e., if all of the AAB is expended within the first three months of the SSP year, it is not justification for an increase in the budget for the SSP year);

(b) revisions to the AAB may occur within the SSP year, and the[~~participant~~] eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect;

(i) the SSP must be amended first to reflect a change in the [~~participant's~~] eligible recipient's needs or circumstances before any revisions to the AAB can be requested;

(ii) other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year.

(c) no mi via program funds can be used to purchase goods or services prior to TPA approval of the SSP and annual budget request;

(d) any funds not utilized within the SSP and AAB year cannot be carried over into the following year;

(6) access consultant services based upon identified need(s) in order to carry out the approved SSP;

(7) collaborate with the consultant to appropriately document service delivery and maintain those documents for evidence of services received;

(8) report concerns or problems with any part of the mi via program to the consultant or if the concern or problem is with the consultant, to MAD or DOH;

(9) work with the TPA agent by attending scheduled meetings, in the [~~participant's~~] eligible recipient's home if necessary and providing documentation as requested;

(10) respond to requests for additional documentation and information from the consultant provider, FMA, and the TPA within the required deadlines;

(11) report to the local HSD income support division (ISD) office within 10 calendar days any change in circumstances, including a change in address, which might affect eligibility for the program. Changes in address or other contact information must also be reported to the consultant provider and the FMA within 10 calendar days;

(12) report to the TPA and consultant provider if hospitalized for more than three consecutive nights so that an appropriate LOC can be obtained; and

(13) keep track of all budget expenditures and assure that all expenditures are within the AAB; and

(14) [~~meet monthly and quarterly with the consultant~~] have monthly contact and meet face-to-face quarterly with the consultant.

C. Additional responsibilities of the [~~participant~~] eligible recipient or EOR:

(1) Submit all required documents to the FMA to meet employer-related responsibilities. This includes, but is not limited to documents for payment to employees and vendors and payment of taxes and other financial obligations within required timelines.

(2) Report any incidents of abuse, neglect or exploitation to the appropriate state [~~entity~~] agency.

(3) Arrange for the delivery of services, supports and goods.

(4) Hire, manage, and terminate employees.

(5) Maintain records and documentation [~~in accordance with 8.302.1.17 NMAC, related to personnel, payroll and service delivery~~].

D. **Voluntary termination:** Current waiver [~~participants~~] the eligible recipients are given a choice of receiving services through an existing waiver or mi via. Mi via [~~participants~~] the eligible recipients, who transition from the current traditional waivers (CoLTS (c), DD, MF, or AIDS) and decide to discontinue self-directing their services, may return to the traditional waiver in accordance with the mi via rules and service standards. [~~Mi via participants~~] The eligible recipients who are eligible under the BI category of eligibility and choose to discontinue self direction may be transitioned to CoLTS (c) services.

E. **Involuntary termination:** A mi via [~~participant~~] eligible recipient may be terminated involuntarily by MAD and offered services through another MAD waiver or the medicaid state plan under the following circumstances.

(1) The [~~participant~~] eligible recipient refuses to follow mi via rules[~~and regulations~~] after receiving focused technical assistance on multiple occasions, support from the program staff, consultant, or FMA, which is supported by documentation of the efforts to assist the [~~participant~~] eligible recipient.

(2) The [~~participant~~] eligible recipient is in immediate risk to his/her health or safety by continued self-direction of services, e.g., the [~~participant~~] eligible recipient is in imminent risk of death or serious bodily injury related to participation in the waiver. Examples include but are not limited to the following:

(a) The [~~participant~~] eligible recipient refuses to include and maintain services in his/her SSP and AAB that would address health and safety issues identified in his/her medical assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, consultant, or FMA.

(b) The [~~participant~~] eligible recipient is experiencing significant health or safety needs, and, after [~~having been referred~~] a referral to the state contractor [~~team~~] for level of risk determination and assistance, refuses to incorporate the [~~team's~~] state contractor's recommendations into his/her SSP and AAB.

(c) The [~~participant~~] eligible recipient exhibits behaviors which endanger him/herself or others.

(3) The [~~participant~~] eligible recipient misuses mi via funds following repeated and focused technical assistance and support from the consultant or FMA, which is supported by documentation.

(4) The [~~participant~~] eligible recipient commits medicaid fraud.

(5) [~~Participant~~] The eligible recipient who is involuntarily terminated from mi via will be offered a non self-directed waiver alternative. If transfer to another waiver is authorized by [~~the state~~] MAD and accepted by the [~~participant~~] eligible recipient, he/she will continue to receive the services and supports from mi via until the day before the new waiver services start. This will ensure that no break in service occurs. The mi via consultant and the service coordinator in the new waiver will work closely together with the [~~participant~~] eligible recipient to ensure that the [~~participant's~~] eligible recipient's health and safety is maintained. [~~Fair hearing notice and rights apply to the participant.~~]

[8.314.6.14 NMAC -Rp, 8.314.6.14 NMAC, 4-1-11; A, 7-1-12]

8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA: The services covered by mi via are intended to provide a community-based alternative to institutional care for an eligible recipient that allows greater choice, direction and control over services and supports in a self-directed environment. Mi via services must specifically address a therapeutic, rehabilitative, habilitative, health or safety need that results from the [~~participant~~] eligible recipient qualifying condition. The mi via program is the payor of last resort. The coverage of mi via services must be in accordance with the mi via program [~~regulations~~].rules and service standards.

A. **General requirements regarding mi via covered services.** [~~For a service to~~] To be considered a covered service under the mi via program, the following criteria must be met. Services, supports and goods must:

(1) directly address the [~~participant's~~] eligible recipient's qualifying condition or disability;

(2) meet the [~~participant's~~] eligible recipient's clinical, functional, medical or habilitative needs;

(3) be designed and delivered to advance the desired outcomes in the [~~participant's~~] eligible recipient's service and support plan; and

(4) support the [~~participant~~] eligible recipient to remain in the community and reduce the risk of institutionalization.

B. **Consultant pre-eligibility/enrollment services:** Consultant pre-eligibility/enrollment services are intended to provide information, support, guidance, and assistance to individuals during the medicaid financial and medical eligibility process. The level of support provided is based upon the unique needs of the individual. When an opportunity to be considered for mi via waiver services is offered to an individual, he/she must complete a primary freedom of choice form. The purpose of this form is for the individual to select a consultant provider. The chosen consultant provider provides pre-eligibility/enrollment services as well as on-going consultant services. Once the individual is determined to be eligible for mi via waiver services, the consultant service provider will continue to provide consultant services to the newly enrolled [~~participant~~] eligible recipient as set forth in the consultant service standards.

C. **Consultant services:** Consultant services are required for all mi via [~~participants~~] eligible recipients to educate, guide, and assist the [~~participant~~] eligible recipients to make informed planning decisions about services and supports. The consultant helps the [~~participant~~] eligible recipient develop the SSP based on his/her assessed needs. The consultant assists the [~~participant~~] eligible recipient with implementation and quality assurance related to the SSP and AAB. Consultant services help the [~~participant~~] eligible recipient identify supports, services and goods that meet his/her needs, meet the mi via requirements and are covered mi via services. Consultant services provide support to [~~participants~~] eligible recipients to maximize their ability to self-direct in mi via.

(1) **Contact requirements:** Consultant providers shall make contact with the [~~participant~~] eligible recipient in person or by telephone at least monthly for a routine follow-up. Consultant providers shall meet in person with the [~~participant~~] eligible recipient at least quarterly; one visit must be conducted in the [~~participant's~~] eligible recipient's home. Quarterly visits will be conducted for the following purposes:

(a) review and document progress on implementation of the SSP;

(b) document usage and effectiveness of the 24-hour em**e**rgency backup plan;

(c) review SSP/budget spending patterns (over and under-utilization);

(d) assess quality of services, supports and functionality of goods in accordance with the quality assurance section of the SSP and any applicable mi via [~~regulations~~] rules and service standards;

(e) document the [~~participant's~~] eligible recipient's access to related goods identified in the SSP;

(f) review any incidents or events that have impacted the [~~participant's~~] eligible recipient's health, welfare or ability to fully access and utilize support as identified in the SSP; and

(g) other concerns or challenges raised by the [~~participant~~] eligible recipient, legal representative, or authorized representative.

(2) **Change of consultants:** Consultants are responsible for assisting [~~participants~~] eligible recipients to transition to another consultant provider when requested. Transition from one consultant provider to another can only occur at the first of the month.

(3) **Critical incident management responsibilities and reporting requirements:** The consultant provider shall provide training to [~~participants~~] eligible recipients and EORs regarding recognizing and reporting critical incidents. Critical incidents include abuse, neglect, exploitation, emergency services, law enforcement involvement, environmental hazards and [~~participant~~] eligible recipient deaths. This [~~participant~~] eligible recipient training shall also include reporting procedures for [~~participants~~] eligible recipients, employees, [~~participants~~] eligible recipients, representatives or other designated individuals. The consultant provider shall report incidents of abuse, neglect and exploitation as directed by the state. The consultant provider shall maintain a critical incident management system to identify, report, and address critical incidents. The consultant provider is responsible for follow-up and assisting the individual to help ensure health and safety when a critical incident has occurred. Critical incident reporting requirements:

(a) For mi via [~~participants~~] eligible recipients who have been designated with an ICF/MR level of care, critical incidents should be directed in the following manner.

[~~(i) The DOH/DHI/incident management bureau (IMB) receives, triages, and investigates all reports of alleged abuse, neglect, exploitation, and other incidents for mi via services provided by community-based waiver service agencies, to include expected and unexpected deaths. The reporting of incidents is mandated pursuant to 7.1.13 NMAC. Any suspected abuse, neglect, or exploitation must be reported to the children, youth and families department (CYFD)/child protective services (CPS) for individuals under the age of 18 or to the ALTSD/adult protective services (APS) for individuals age 18 or older by reporting or faxing an incident report (IR). Additionally, the IR form must be faxed to DOH/DHI within 24 hours of knowledge of an incident or the following business day when an event occurs on a weekend or holiday. Anyone may report an incident; however, the person with the most direct knowledge of the incident is the individual who is required to report the incident.~~

~~(ii) When an incident is reported late, and the mi via service is provided by a community-based waiver service agency, a letter is sent to the provider stating that an incident report was received beyond the required 24-hour timeline for reporting. The letter further reiterates the requirement to report incidents within 24 hours. The consequences of non-compliance may result in sanctions, as set forth in 7.1.13.12 NMAC.~~

~~(iii) With respect to waiver services provided by any employee, contractor or vendor other than a community-based waiver service agency, any suspected abuse, neglect, or exploitation must be reported to the CYFD/CPS for individuals under the age of 18 or to the ALTSD/APS for individuals age 18 or older by reporting or faxing an incident report. See NMSA 1978, Sections 27-7-14 through 27-7-31 (Adult Protective Services Act) and in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).~~

~~(b) For individuals in mi via that have been designated with an NF-LOC, critical incidents should be directed to:~~

~~(i) ALTSD/APS for individuals age 18 or older or CYFD/CPS for individual under the age of 18 for critical incidents involving abuse, neglect or exploitation; and~~

~~(ii) HSD/MAD, quality assurance bureau as well as the managed care organization, if applicable; the consultant provider shall fax all critical incidents in the standardized format provided by the state.~~]

(i) The DOH triages, and investigates all reports of alleged abuse, neglect, exploitation, and other incidents for mi via services provided by community-based waiver service agencies, to include expected and unexpected deaths. The reporting of incidents is mandated pursuant to 7.1.13 NMAC. Any suspected abuse, neglect, or exploitation must be reported to the children, youth and families department (CYFD)/child protective services (CPS) for eligible recipients under 18 years or to the ALTSD/adult protective services (APS) for eligible recipients 18 years or older by reporting or faxing an incident report (IR). Additionally, the IR form must be faxed to DOH within 24 hours of knowledge of an incident or the following business day when an event occurs on a

weekend or holiday. Anyone may report an incident; however, the person with the most direct knowledge of the incident is the individual who is required to report the incident.

(ii) When an incident is reported late, and the mi via service is provided by a community-based waiver service agency, a letter is sent to the provider stating that an incident report was received beyond the required 24-hour timeline for reporting. The letter further reiterates the requirement to report incidents within 24 hours. The consequences of non-compliance may result in sanctions, as set forth in 7.1.13.12 NMAC.

(iii) With respect to waiver services provided by any employee, contractor or vendor other than a community-based waiver service agency, any suspected abuse, neglect, or exploitation must be reported to the CYFD/CPS for the eligible recipient under 18 years or to the ALTSD/APS for eligible recipients age 18 years or older by reporting or faxing an incident report. See NMSA 1978, Sections 27-7-14 through 27-7-31 (Adult Protective Services Act) and in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).

(b) For eligible recipients in mi via that have been designated with an NF LOC, critical incidents should be directed to:

(i) ALTSD/APS for eligible recipients age 18 years or older or CYFD/CPS for eligible recipients under 18 years for critical incidents involving abuse, neglect or exploitation; and

(ii) MAD, quality assurance bureau as well as the MCO, if applicable; the consultant provider shall fax all critical incidents in the standardized format provided by the CYFD/CPS and ALTSD/APS.

D. **Personal plan facilitation:** Personal plan facilitation supports planning activities that may be used by the [~~participants~~] eligible recipient to develop his/her SSP as well as identify other sources of support outside the SSP process. This service is available to [~~participants~~] an eligible recipient one time per budget year.

(1) In the scope of personal planning facilitation, the personal plan facilitator will:

(a) meet with the [~~participant~~] eligible recipient and his/her family (or legal representative, as appropriate) prior to the personal planning session to discuss the process, to determine who the [~~participant~~] eligible recipient wishes to invite, and determine the most convenient date, time and location; this meeting preparation shall include an explanation of the techniques the facilitator is proposing to use or options if the facilitator is trained in multiple techniques; the preparation shall also include a discussion of the role the [~~participant~~] eligible recipient prefers to play at the planning session, which may include co-facilitation of all or part of the session;

(b) arrange for participation of invitees and location;

(c) conduct the personal planning session;

(d) document the results of the personal planning session and provide a copy to the [~~participant~~] eligible recipient, the consultant and any other parties the [~~participant~~] eligible recipient would like to receive a copy.

(2) Elements of this report shall include:

(a) recommended services to be included in the SSP;

(b) services from sources other than [~~medicaid~~] MAD to aid the [~~participant~~] eligible recipient;

(c) long-term goals the participant wishes to pursue;

(d) potential resources, especially natural supports within the [~~participant's~~] eligible recipient's community that can help the [~~participant~~] eligible recipient to pursue his or her desired outcomes(s)/goal(s); and

(e) a list of any follow-up actions to take, including time lines.

(3) Provide session attendees, including the [~~participant~~] eligible recipient, with an opportunity to provide feedback regarding the effectiveness of the session.

E. **Living supports:**

(1) **Homemaker/direct support services:** Homemaker/direct support services are provided on an episodic or continuing basis to assist the [~~participant~~] eligible recipient with activities of daily living, performance of general household tasks, and enable the [~~participant~~] eligible recipient to accomplish tasks he/she would normally do for him/herself if he/she did not have a disability. Homemaker/direct support services are provided in the [~~participant's~~] eligible recipient's home and in the community, depending on the [~~participant's~~] eligible recipient's needs. The [~~participant~~] eligible recipient identifies the homemaker/direct support worker's training needs, and, if the [~~participant~~] eligible recipient is unable to do the training him/herself, the [~~participant~~] eligible recipient arranges for the needed training. Services are not intended to replace supports available from a primary caregiver.

(a) Two or more [~~participants~~] eligible recipients living in the same residence, who are receiving services and supports from mi via will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved based on common needs and not individual needs, unless the TPA has assessed that the eligible recipient has [~~there is~~] an individual need for the services.

(b) Personal care services are covered under the medicaid state plan as [~~expanded EPSDT~~] enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for waiver [~~participants~~] eligible recipients under [~~age~~] 21 years.

(2) **Home health aide services:** Home health aide services provide total care or assist an [~~adult participant~~] eligible recipient 21 years and older in all activities of daily living. Home health aide services assist the [~~participant~~] eligible recipient in a manner that will promote an improved quality of life and a safe environment for the [~~participant~~] eligible recipient. Home health aide services can be provided outside the [~~participant's~~] eligible recipient's home. State plan home health aide services are intermittent and provided primarily on a short-term basis. Mi via home health aide services are hourly services for [~~participants~~] eligible recipients who need this service on a more long-term basis. Home health aide services are not duplicative of homemaker services. Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks.

(3) **Assisted living:** A residential service that includes personal care and supportive services (homemaker, chore, attendant services, meal preparation); medication oversight (to the extent permitted under state law); and 24-hour, on-site response capability to meet scheduled or unpredictable [~~participant~~] eligible recipient needs and to provide supervision, safety, and security.

(a) Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board.

(b) Nursing and skilled therapy services are incidental, rather than integral, to the provision of assisted living services.

(c) Services (other than those included in the bundle of "assisted living" services) provided by third parties must be coordinated with the assisted living provider.

(d) [~~Participants~~] Eligible recipients who [~~access~~] utilize this service cannot utilize mi via homemaker/direct support, environmental modifications, emergency response, customized community supports and customized in-home living supports services because they are provided by assisted living services.

(4) **Customized in-home living supports:** Customized in-home living supports are related to the [~~participant's~~] eligible recipient's qualifying condition or disability and enable him/her to live in his /her apartment or house. Services must be provided in homes/apartments owned or leased by the [~~participant~~] eligible recipient or in the [~~participant's family~~] eligible recipient's home.

(a) These services and supports are provided in the [~~participant's~~] eligible recipient's home and are individually designed to instruct or enhance home living skills as well as address health and safety.

(b) Customized in-home living supports include assistance with activities of daily living and assistance with the acquisition, restoration, or retention of independent living skills. This service is provided on a regular basis at least four or more hours per day one or more days per week as specified in the service plan.

(c) [~~Participants~~] Eligible recipients receiving customized in-home living supports may not use homemaker/direct support or home health aide services because they are provided by customized in-home living supports.

F. **Community membership supports:**

(1) **Community direct support:** Community direct support providers deliver support to the [~~participant~~] eligible recipient to identify, develop and maintain community connections and access social and educational options.

(a) The community direct support provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the [~~participant~~] eligible recipient to access the community.

(b) The community direct support provider may instruct and model social behavior necessary for the [~~participant~~] eligible recipient to interact with community members or in groups, provide assistance in ancillary tasks related to community membership, provide attendant care and help the [~~participant~~] eligible recipient schedule, organize and meet expectations related to chosen community activities.

(c) Community direct support services include:

(i) provide assistance to the [~~participant~~] eligible recipient outside of his/her residence and segregated facilities;

(ii) promote the development of social relationships and build connections within local communities;

(iii) support the [~~participant~~] eligible recipient in having frequent opportunities to expand roles in the community to increase and enhance natural supports, networks, friendships and build a sense of belonging; and

(iv) assist in the development of skills and behaviors that strengthen the [~~participant's~~] eligible recipient's connection with his or her community.

(d) The skills to assist someone in a community setting may be different than those for assisting [~~a person~~] an eligible recipient at home. The provider will:

(i) demonstrate knowledge of the local community and resources within that community that are identified by the [~~participant~~] eligible recipient on the SSP; and

(ii) be aware of the [~~participant's~~] eligible recipient's barriers to communicating and maintaining health and safety while in the community setting.

(2) **Employment supports:** Employment supports include job development, support to find a job, and job coaching after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that [~~a participant~~] an eligible recipient may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational or vocational assessments and profiles; education of the [~~participant~~] eligible recipient and co-workers on rights and responsibilities; and benefits counseling.

(a) Job development is a service provided to [~~participants~~] eligible recipients by skilled staff. The service has five components:

(i) job identification and development activities;

(ii) employer negotiations;

(iii) job restructuring;

(iv) job sampling; and

(v) job placement.

(b) Employment supports will be provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by [~~participants~~] eligible recipients receiving waiver 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.

(c) Documentation is maintained in the file of each [~~participant~~] eligible recipient receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA.

(d) FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

(i) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(ii) payments that are passed through to users of supported employment programs; or

(iii) payments for training that is not directly related to an individual's supported employment program;

(iv) FFP cannot be claimed to defray expenses associated with starting up or operating a business.

(3) **Customized community supports:** Customized community supports can 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 for an eligible recipient. Customized community supports may include adult day habilitation, adult day health and other day support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings. These services are provided at least four or more hours per day one or more days per week as specified in the [~~participant's~~] eligible recipient's SSP.

G**. Health and wellness:**

(1) **Extended state plan skilled therapy for [~~adults~~] eligible recipients 21 years and older:** [~~Extended~~] Enhanced state plan skilled therapy for adults includes physical therapy, occupational therapy or speech language therapy. CoLTS services are provided when [~~state plan skilled therapy services are exhausted~~] skilled therapy services under the state plan are exhausted or not a benefit. [~~Adults~~] Eligible recipients 21 years and older on mi via access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to [~~adults~~] eligible recipients 21 years or older in mi via focus on improving functional independence, health maintenance, community integration, socialization, and exercise, or enhance support and normalization of family relationships.

(a) **Physical therapy:** Diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance and

promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy activities do the following:

(i) increase, maintain or reduce the loss of functional skills;

(ii) treat a specific condition clinically related to [~~a participant's~~] the eligible recipient's disability;

(iii) support the [~~participant's~~] eligible recipient's health and safety needs; or

(v) identify, implement, and train on therapeutic strategies to support the [~~participant~~] eligible recipient and his/her family or support staff consistent with the [~~participant's~~] eligible recipient's SSP desired outcomes and goals.

(b) **Occupational therapy:** 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. Occupational therapy services typically include:

(i) customized treatment programs to improve the [~~participant's~~] eligible recipient's ability to perform daily activities;

(ii) comprehensive home and job site evaluations with adaptation recommendations;

(iii) skills assessments and treatment;

(iv) assistive technology recommendations and usage training;

(v) guidance to family members and caregivers;

(vi) increasing or maintaining functional skills or reducing the loss of functional skills;

(vii) treating specific conditions clinically related to [~~a participant~~] the eligible recipient's developmental disability;

(viii) support for the [~~participant's~~] eligible recipient's health and safety needs, and

(ix) identifying, implementing, and training therapeutic strategies to support the [~~participant~~] eligible recipient and his/her family or support staff consistent with the [~~participant's~~] eligible recipient's SSP desired outcomes and goals.

(c) **Speech and language pathology:** Diagnosis, counseling and instruction related to the development and disorders of communication including speech fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal, and sensor motor competencies. Speech language pathology is also used when [~~a participant~~] an eligible recipient 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. Services are intended to:

(i) improve or maintain the [~~participant's~~] eligible recipient's capacity for successful communication or to lessen the effects of the [~~participant's~~] eligible recipient's loss of communication skills; or

(ii) improve or maintain the [~~participant's~~] eligible recipient's ability to eat foods, drink liquids, and manage oral secretions with minimal risk of aspiration or other potential injuries or illness related to swallowing disorders;

(iii) identify, implement and train therapeutic strategies to support the [~~participant~~] eligible recipient and his/her family or support staff consistent with the [~~participant's~~] eligible recipient's SSP desired outcomes and goals.

(d) **Behavior support consultation:** Behavior support consultation services consist of functional support assessments, treatment plan development, and training and support coordination for [~~a participant's~~] the eligible recipient's related to behaviors that compromise [~~a participant's~~] the eligible recipient's quality of life. Based on the [~~participant's~~] eligible recipient's SSP, services are delivered in an integrated, natural setting, or in a clinical setting. Behavior support consultation:

(i) informs and guides the [~~participant's~~] eligible recipient's service and support employees/vendors toward understanding the contributing factors to the [~~participant's~~] eligible recipient's behavior;

(ii) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s);

(iii) supports effective implementation based on a functional assessment and SSP;

(iv) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues, and to limit the need for psychotherapeutic medications; and

(v) monitors and adapts support strategies based on the response of the [~~participant~~] eligible recipient and his/her service and support providers.

(e) **Nutritional counseling:** Nutritional counseling services include assessment of the [~~participant's~~] eligible recipient's nutritional needs, development or revision of the [~~participant's~~] eligible recipient's

nutritional plan, counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.

(f) **Private duty nursing for adults:** Private duty nursing for [~~adults~~] eligible recipients 21 years or older includes activities, procedures, and treatment for [~~a participant's~~] the eligible recipient's physical condition, physical illness or chronic disability. Services include medication management, administration and teaching, aspiration precautions, feeding tube management, gastrostomy and jejunostomy care, 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, behavior and self-care assistance.

(2) **Specialized therapies:** Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. Experimental or investigational procedures, technologies or therapies and those services covered as a medicaid state plan benefit are excluded. Services in this category include the following therapies:

(a) **Acupuncture:** Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. See acupuncture and oriental medicine practitioners 16.2.1 NMAC.

(b) **Biofeedback:** Biofeedback uses visual, auditory or other monitors to feed back to [~~patients~~] eligible recipients physiological information of which they are normally unaware. This technique enables an [~~individual~~] eligible recipient to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

(c) **Chiropractic:** 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, for the purpose of restoring and maintaining 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, increase range of motion, and lead to improved general health. See 16.4.1 NMAC.

(d) **Cognitive rehabilitation therapy:** Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for 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.

(e) **Hippotherapy:** Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for [~~individuals~~] eligible recipients with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the [~~individual~~] eligible recipient use cognitive functioning, especially for sequencing and memory. [~~Individuals~~] Eligible recipients 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.

(f) **Massage therapy:** Massage therapy is the assessment and treatment of soft tissues and their dysfunctions 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 the 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, an [~~individual's~~] eligible recipient'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.

(g) **Naprapathy:** 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 other 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.

(h) **Native American healers:** Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support [~~participants~~] eligible recipients in their communities by addressing their physical, emotional and spiritual health. Treatments may include prayer, dance, ceremony, song, plant medicines, foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel or other sacred objects.

(i) **Play therapy:** Play therapy is a variety of play and creative arts techniques [~~("the play therapy tool kit")~~] utilized to alleviate chronic, mild and moderate psychological and emotional conditions [~~in children~~] for an eligible recipient that are causing behavioral problems or are preventing [~~children~~] the eligible recipient from realizing [~~their~~] his/her potential. The play therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the [~~child's wishes~~] the eligible recipient's direction.

H. **Other supports:**

(1) **Transportation:** Transportation services are offered to enable [~~participants~~] eligible recipients to gain access to services, activities, and resources, as specified by the SSP. Transportation services under the waiver are offered in accordance with the [~~participant's~~] eligible recipient's SSP. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the medicaid state plan are to transport [~~participants~~] eligible recipients to medically necessary physical and behavioral health services. Payment for mi via transportation services is made to the [~~participant's~~] eligible recipient's individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the [~~participant~~] eligible recipient. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge shall be identified in the SSP and utilized.

(2) **Emergency response services:** Emergency response services provide an electronic device that enables [~~a participant~~] the eligible recipient to secure help in an emergency at home and avoid institutionalization. The [~~participant~~] eligible recipient may also wear a portable help button to allow for mobility. The system is connected to the [~~participant's~~] eligible recipient's phone and programmed to signal a response center when a help button is activated. The response center is staffed by trained professionals. Emergency response services include:

(a) testing and maintaining equipment;

(b) training [~~participants~~] eligible recipients, caregivers and first responders on use of the equipment;

(c) 24-hour monitoring for alarms;

(d) checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.;

(e) reporting emergencies and changes in the [~~participant's~~] eligible recipient's condition that may affect service delivery; and

(f) ongoing emergency response service is covered, but initial set up and installation is not.

(3) **Respite:** Respite is a family support service, the primary purpose of which is to give the primary, unpaid caregiver time away from his/her duties. Respite services include assisting the [~~participant~~] eligible recipient with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the [~~participant~~] eligible recipient to enhance self-help skills, leisure time skills and community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the [~~participant~~] eligible recipient to make his/her own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the [~~participant's~~] eligible recipient's home, the provider's home, in a 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. FFP is not claimed for the cost of room and board as part of respite services.

(4) **Related goods:** Related goods are equipment, supplies or fees and memberships, not otherwise provided through mi via, the medicaid state plan, or medicare.

(a) Related goods must address a need identified in the [~~participant's~~] eligible recipient's SSP and meet the following requirements:

(i) be responsive to the[~~participant's~~] eligible recipient's qualifying condition or disability; and

(ii) meet the [~~participant's~~] eligible recipient's clinical, functional, medical or habilitative needs; and

(iii) supports the [~~participant~~] eligible recipient to remain in the community and reduces the risk for institutionalization; and

(iv) promote personal safety and health; and afford the [~~participant~~] eligible recipient an accommodation for greater independence; and

(v) decrease the need for other medicaid services; and

(vi) accommodate the [~~participant~~] eligible recipient in managing his/her household; or

(vii) facilitate activities of daily living.

(b) Related goods must be documented in the SSP, comply with Paragraph (3) of Subsection D of 8.314.6.17 NMAC, and be approved by the TPA. The cost and type of related good is subject to approval by the TPA. [~~Participants~~] Eligible recipients are not guaranteed the exact type and model of related good that is requested. The consultant, TPA or the state can work with the [~~participant~~] eligible recipient to find other (including less costly) alternatives.

(c) The related goods must not be available through another source and the [~~participant~~] eligible recipient must not have the personal funds needed to purchase the goods.

(d) These items are purchased from the [~~participant's~~] eligible recipient's AAB.

(e) Experimental or prohibited treatments and goods are excluded.

(5) **Environmental modifications:** Environmental modification services include the purchase and installation of equipment or making physical adaptations to [~~a participant's~~] the eligible recipient's residence that are necessary to ensure the health, safety, and welfare of the [~~participant~~] eligible recipient or enhance the [~~participant~~] eligible recipient level of independence.

(a) Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, 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 or signaling devices.

(b) All services shall be provided in accordance with applicable federal, state, and local building codes.

(c) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the [~~participant~~] eligible recipient, such as fences, storage sheds or other outbuildings. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

(d) The environmental modification provider must: ensure proper design criteria is addressed in the planning and design of the adaptation; be a licensed and insured contractor(s) or approved vendor(s) that provides construction/remodeling services; provide administrative and technical oversight of construction projects; provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the participant's residence; and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

(e) Environmental modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects.

(f) Environmental modification services are limited to $7,000 every five years. Environmental modifications must be approved by the TPA.

(g) Environmental modifications are paid from a funding source separate from the AAB.

[8.314.6.15 NMAC - Rp, 8.314.6.15 NMAC, 4-1-11; A, 4-1-12]

8.314.6.16 NON-COVERED SERVICES: Non-covered services include, but are not limited to the following:

A. services covered by the medicaid state plan (including EPSDT), [~~medicaid~~] MAD school-based services, medicare and other third-parties;

B. any service or good, the provision of which would violate federal or state statutes, regulations or guidance;

C. formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by [~~DVR~~] the public education department (PED), division of vocational rehabilitation (DVR).

D. [~~room and board, meaning~~] food and shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing, maintenance, utilities and utility deposits, and related administrative expenses; utilities include gas, electricity, propane, fire wood, wood pellets, water, sewer, and waste management;

E. experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC *Experimental or Investigational Procedures, Technologies or Therapies*;

F. any goods or services that a household that does not include a person with a disability would be expected to pay for as a routine household expense;

G. any goods or services that are to be used primarily for recreational or diversional purposes;

H. personal goods or items not related to the disability;

I. animals and 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;

J. gas cards and gift cards;

K. purchase of insurance, such as car, health, life, burial, renters, home-owners, service warrantees or other such policies;

L. purchase of a vehicle, and long-term lease or rental of a vehicle;

M. purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items;

N. firearms, ammunition or other weapons;

O. gambling, games of chance (such as bingo or lottery), alcohol, tobacco, or similar items;

P. vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses;

Q. purchase of usual and customary furniture and home furnishings, *unless* adapted to the [~~participant's~~] eligible recipient's disability or use, or of specialized benefit to the [~~participant's~~] eligible recipient's condition; requests for adapted or specialized furniture or furnishings must include a recommendation from the [~~participant's~~] eligible recipient's health care provider and, when appropriate, a denial of payment from any other source;

R. regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, *except* upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the [~~participant's~~] eligible recipient's qualifying condition or disability;

S. regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, *except* upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the [~~participant's~~] eligible recipient's qualifying condition or disability; requests must include documentation that the adapted vehicle is the [~~participant's~~] eligible recipient's primary means of transportation;

T. clothing and accessories, except specialized clothing based on the [~~participant's~~] eligible recipient's disability or condition;

U. training expenses for paid employees;

V. conference or class fees may be covered for [~~participants~~] eligible recipients or unpaid caregivers, but costs associated with such conferences or class cannot be covered, including airfare, lodging or meals;

W. consumer electronics such as computers, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.15 NMAC; no more than one of each type of item may be purchased at one time; and consumer electronics may not be replaced more frequently than once every three years;

X. cell phone services that include: fees for data; or more than one cell phone line per [~~participant~~] eligible recipient; and

Y. if [~~a participant~~] the eligible recipient requests a good or service, the consultant TPA and the state can work with the [~~participant~~] eligible recipient to find other (including less costly) alternatives.

[8.314.6.16 NMAC - Rp, 8.314.6 NMAC, 4-1-11; A, 4-1-12]

8.314.6.17 SERVICE AND SUPPORT PLAN (SSP) AND AUTHORIZED ANNUAL BUDGET(AAB): An SSP and an annual budget request are developed at least annually by the mi via [~~participant~~] eligible recipient in

collaboration with the [~~participant's~~] eligible recipient's consultant and others that the [~~participant~~] eligible recipient invites to be part of the process. The consultant serves in a supporting role to the mi via [~~participant~~] eligible recipient, assisting the [~~participant~~] eligible recipient to understand mi via, and with developing and implementing the SSP and the AAB. The SSP and annual budget request are developed and implemented in accordance with the mi via program rules and service standards and submitted to the TPA for final approval. Upon final approval the annual budget request becomes an AAB.

A. **SSP development process:** For development of the participant-centered service plan, the planning meetings are scheduled at times and locations convenient to the [~~participant~~] eligible recipient. The state obtains information about [~~participant~~] eligible recipient strengths, capacities, preferences, desired outcomes and risk factors through the LOC assessment and the planning process that is undertaken between the consultant and [~~participant~~] eligible recipient to develop the participant's SSP. If the participant chooses to purchase personal plan facilitation services, that assessment information would also be used in developing the SSP.

(1) **Assessments:**

(a) Assessment activities that occur prior to the SSP meeting assist in the development of an accurate and functional plan. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social and employment; LOC assessments are conducted in person and take place in the [~~applicant/participant's~~] or the eligible recipient's home, an agreed upon location or an inpatient setting.

(b) Assessments occur on an annual basis or during significant changes in circumstance or at the time of the LOC determination. After the assessments are completed, the results are made available to the [~~participant~~] eligible recipient and his/her consultant for use in planning.

(c) The [~~participant~~] eligible recipient and the consultant will assure that the SSP addresses the information and concerns, if any, identified through the assessment process.

(d) [~~Participant/employer~~] Eligible recipient/employer self assessments are completed prior to SSP meetings ([~~participant/employer~~] eligible recipient/employer self assessments may be revised during the year to address any life changes). The SSP must address areas of need, as recognized in the [~~participant/employer~~] eligible recipient/employer self-assessment.

(2) **Pre-planning:**

(a) The consultant contacts the [~~participant~~] eligible recipient upon his/her choosing mi via to provide information regarding mi via, including the range and scope of choices and options, as well as the rights, risks, and responsibilities associated with self-direction.

(b) The consultant discusses areas of need to address on the [~~participant's~~] eligible recipient's SSP. The consultant provides support during the annual recertification process to assist with completing medical and financial eligibility in a timely manner.

(c) Personal plan facilitators are optional supports. To assist in pre-planning, the [~~participant~~] eligible recipient is also able to access an approved provider to develop a personal plan.

(3) **SSP components:** The SSP contains:

(a) the waiver services that are furnished to the mi via [~~participant~~] eligible recipient, the projected amount, frequency and duration, and the type of provider who furnishes each service;

(i) the SSP must describe in detail how the services or goods relate to the [~~participant's~~] eligible recipient's qualifying condition or disability;

(ii) the SSP must describe how the services and goods support the [~~participant~~] eligible recipient to remain in the community and reduce his/her risk of institutionalization; and

(iii) the SSP must specify the hours of services to be provided and payment arrangements;

(b) other services needed by the mi via [~~participant~~] eligible recipient regardless of funding source, including state plan services;

(c) informal supports that complement waiver services in meeting the needs of the[~~participant~~] eligible recipient;

(d) methods for coordination with state plan services and other public programs;

(e) methods for addressing the [~~participant's~~] eligible recipient's health care needs when relevant;

(f) quality assurance criteria to be used to determine if the services and goods meet the [~~participant's~~] eligible recipient's needs as related to his/her qualifying condition or disability;

(g) information, resources or training needed by the mi via [~~participant~~] eligible recipient and service providers;

(h) methods to address the [~~participant's~~] eligible recipient's health and safety, such as 24-hour emergency and back-up services; and

(i) the IBA.

(4) **Service and support plan meeting:**

(a) The[~~participant~~] eligible recipient receives an LOC assessment and local resource manual prior to the SSP meeting.

(b) The [~~participant~~] eligible recipient may begin planning and drafting the SSP utilizing those tools prior to the SSP meeting.

(c) During the SSP meeting, the consultant assists the [~~participant~~] eligible recipient to ensure that the SSP addresses the [~~participant's~~] eligible recipient's goals, health, safety and risks. The[~~participant~~] eligible recipient and the consultant will assure that the SSP addresses the information and concerns identified through the assessment process. The SSP must address the [~~participant's~~] eligible recipient's health and safety needs before addressing other issues. The consultant ensures that:

(i) the planning process addresses the [~~participant's~~] eligible recipient's needs and goals in the following areas: health and wellness and accommodations or supports needed at home and in the community;

(ii) services selected address the[~~participant's~~] eligible recipient's needs as identified during the assessment process; needs not addressed in the SSP will be addressed outside the mi via program;

(iii) the outcome of the assessment process for assuring health and safety is considered in the plan;

(iv) services do not duplicate or supplant those available to the [~~participant~~] eligible recipient through the medicaid state plan or other programs;

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

(vi) job descriptions are complete for each provider and employee in the plan; job descriptions will include frequency, intensity and expected outcomes for the service;

(vii) the quality assurance section of the SSP is complete and specifies the roles of the [~~participant~~] eligible recipient, consultant and any others listed in this section;

(viii) the responsibilities are assigned for implementing the plan;

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

(x) the SSP is submitted to the TPA after the SSP meeting, in compliance with mi via waiver rules.

B. **Individual budgetary allotment (IBA):** Each mi via [~~participant's~~] eligible recipient's annual IBA is determined by the state as follows.

(1) Budgetary allotments are based on calculations developed by the state for each mi via population group, including AIDS, former Disabled & Elderly (D&E) now CoLTS (c), DD or MF waiver, and BI category of eligibility, utilizing historical traditional waiver care plan authorized budgets within the population, minus the case management costs, and minus a 10 percent discount.

(2) The determination of each mi via [~~participant's~~] eligible recipient's sub-group is based on a comprehensive assessment. The [~~participant~~] eligible recipient then receives the IBA available to that category of need, according to the [~~participant's~~] eligible recipient's age.

(3) A mi via [~~participant~~] eligible recipient has the authority to expend the IBA through an AAB that is to be expended on a monthly basis and in accordance with the mi via rules and program service standards.

(a) The current mi via rate schedule, available on the HSD/MAD website under fee schedules, shall be used as a guide in evaluating proposed payment rates for services that are currently covered or similar to currently covered services. The [~~participant~~] eligible recipient must justify in writing the rate that he/she wishes to pay when that rate exceeds the rate schedule. The [~~participant~~] eligible recipient must include this justification with the SSP and annual budget request when it is submitted for approval.

(b) The AAB shall contain goods and services necessary for health and safety (i.e. direct care services and medically related goods) which will be given priority over goods and services that are non-medical or not directly related to health and safety. This prioritization applies to the IBA, AAB, and any subsequent modifications.

C. **SSP review criteria:** Services and related goods identified in the [~~participant's~~] eligible recipient's requested SSP may be considered for approval if the following requirements are met:

(1) the services or goods must be responsive to the [~~participant's~~] eligible recipient's qualifying condition or disability; and

(2) the services or goods must address the [~~participant's~~] eligible recipient's clinical, functional, medical or habilitative needs; and

(3) the services or goods must accommodate the[~~participant~~] eligible recipient in managing his/her household; or

(4) the services or goods must facilitate activities of daily living; or

(5) the services or goods must promote the [~~participant's~~] eligible recipient's personal health and safety; and

(6) the services or goods must afford the [~~participant~~] eligible recipient an accommodation for greater independence; and

(7) the services or goods must support the [~~participant~~] eligible recipient to remain in the community and reduce his/her risk for institutionalization; and

(8) the services or goods must be documented in the SSP and advance the desired outcomes in the [~~participant's~~] eligible recipient's SSP; and

(9) the SSP contains the quality assurance criteria to be used to determine if the service or goods meet the [~~participant's~~] eligible recipient's need as related to the qualifying condition or disability; and

(10) the services or goods must decrease the need for other [~~medicaid~~] MAD services; and

(11) the [~~participant~~] eligible recipient receiving the services or goods does not have the funds to purchase the services or goods; or

(12) the services or goods are not available through another source; the [~~participant~~] eligible recipient must submit documentation that the services or goods are not available through another source, such as the medicaid state plan or medicare; and

(13) [~~the service or good is not prohibited by federal and state statutes, regulations and guidance; and~~] the service or good is not prohibited by federal regulations, state rules and instructions; and

(14) each service or good must be listed as an individual line item whenever possible; when services or goods are 'bundled' the SSP must document why bundling is necessary and appropriate.

D. **Budget review criteria:** The [~~participant's~~] eligible recipient's proposed annual budget request may be considered for approval, if all of the following requirements are met:

(1) the proposed annual budget request is within the [~~participant's~~] eligible recipient's IBA; and

(2) the proposed rate for each service is within the mi via range of rates for that chosen service; and

(3) the proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and

(4) the estimated cost of the service or good is specifically documented in the [~~participant's~~] eligible recipient's budget worksheets; and

(5) no employee exceeds 40 hours paid work in a consecutive seven-day period.

E. **Modification of the SSP:**

(1) The SSP may be modified based upon a change in the [~~participant's~~] eligible recipient's needs or circumstances, such as a change in the [~~participant's~~] eligible recipient's health status or condition or a change in the [~~participant's~~] eligible recipient's support system, such as the death or disabling condition of a family member or other individual who was providing services.

(2) If the modification is to provide new or additional services than originally included in the SSP, these services must not be able to be acquired through other programs or sources. The [~~participant~~] eligible recipient must document the fact that the services are not available through another source.

(3) The [~~participant~~] eligible recipient must provide written documentation of the change in needs or circumstances as specified in the mi via service standards. The [~~participant~~] eligible recipient submits the documentation to the consultant. The consultant initiates the process to modify the SSP by forwarding the request for modification to the TPA for review.

(4) The SSP must be modified before there is any change in the AAB.

(5) The SSP may be modified once the original SSP has been submitted and approved. Only one SSP revision may be submitted at a time, e.g., an SSP revision may not be submitted if an initial SSP request or prior SSP revision request is under initial review by the TPA. This requirement also applies to any re-review or re-consideration of the same revision request. Other than for critical health and safety reasons, neither the SSP nor the AAB may be modified within 60 days of expiration of the current SSP.

F. **Modifications to the annual budget:** Revisions to the AAB may occur within the SSP year, and the [~~participant~~] eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. The SSP must be amended first to reflect a change in the [~~participant's~~] eligible recipient's needs or circumstances before any revisions to the AAB can be requested.

(1) Budget revisions involve requests to add new goods or services to a budget or to reallocate funds from any line item to another approved line item. Budget revisions must be submitted to the TPA for review and

approval. Other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 days of the budget year.

(2) The amount of the AAB cannot exceed the [~~participant's~~] eligible recipient's annual IBA. The rare exception would be [~~a participant~~] the eligible recipient whose assessed or documented needs, based on his/her qualifying condition, cannot be met within the annual IBA, in which case the [~~participant~~] eligible recipient would initiate a request for an adjustment through his/her consultant.

(3) If the [~~participant~~] eligible recipient requests an increase in his/her budget above his/her annual IBA, the [~~participant~~] eligible recipient must show one of the following circumstances:

(a) chronic physical condition: the [~~participant~~] eligible recipient has one or more chronic physical conditions, which are identified during the initial or reevaluation of the LOC, that result in a prolonged dependency on medical services or care, for which daily intervention is medically necessary; the [~~participant's~~] eligible recipient's needs cannot be met within the assigned IBA or other current resources, including natural supports, medicaid state plan services, medicare or other sources; and which are characterized by at least one of the following:

(i) a life-threatening condition with frequent or constant periods of acute exacerbation that places the[~~participant~~] eligible recipient at risk for institutionalization; that could result in the [~~participant's~~] eligible recipient's inability to remember to self-administer medications accurately even with the use of assistive technology devices; that requires a frequency and intensity of assistance, supervision, or consultation to ensure the [~~participant's~~] eligible recipient's health and safety in the home or in the community; or which, in the absence of such skilled intervention, assistance, medical supervision or consultation, would require hospitalization or admission to an NF or ICF/MR;

(ii) the need for administration of specialized medications, enteral feeding or treatments that: are ordered by a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant; and require frequent and ongoing management or monitoring or oversight of medical technology;

(b) change in physical health status; the [~~participant~~] eligible recipient has experienced a deterioration or permanent change in her/her health status such that the[~~participant's~~] eligible recipient's needs for services and supports can no longer be met within the AAB or other current resources, including natural supports, are not covered under the medicaid state plan, medicare or other sources; these are the types of changes that may necessitate an increase in the AAB; the [~~participant~~] eligible recipient now requires the administration of medications via intravenous or injections on a daily or weekly basis; the [~~participant~~] eligible recipient has experienced recent onset or increase in aspiration of saliva, foods or liquids; the [~~participant~~] eligible recipient now requires external feedings, e.g. naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube; the [~~participant~~] eligible recipient is newly dependent on a ventilator; the [~~participant~~] eligible recipient now requires suctioning every two hours, or more frequently, as needed; the [~~participant~~] eligible recipient now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; the [~~participant~~] eligible recipient now requires increased assistance with activities of daily living;

(i) the [~~participant~~] eligible recipient must submit a written, dated, and signed evaluation or letter from a medical specialist either a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant that documents the change in the [~~participant's~~] eligible recipient's health status relevant to the above criteria; the evaluation or letter must have been completed since the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent;

(ii) the [~~participant~~] eligible recipient may submit additional supportive documentation by others involved in the [~~participant's~~] eligible recipient's care, such as a current individual service plan if the [~~participant~~] eligible recipient is transferring from another waiver, a recent evaluation from a specialist or therapist, a recent discharge plan, relevant medical records or other documentation or recent statements from family members, friends or other support individuals;

(c) chronic or intermittent behavioral conditions or cognitive difficulties: the [~~participant~~] eligible recipient has chronic or intermittent behavioral conditions or cognitive difficulties, which are identified during the initial or reevaluation LOC assessment, or the [~~participant~~] eligible recipient has experienced a change in his/her behavioral [~~or mental~~] health status, for which the [~~participant~~] eligible recipient requires additional services, supports, assistance, or supervision to address the behaviors or cognitive difficulties in order to keep the [~~participant~~] eligible recipient safe; these behaviors and cognitive difficulties are so severe and intense that they result in considerable risk to the [~~participant~~] eligible recipient, caregivers or the community; require a frequency and intensity of assistance, supervision or consultation to ensure the [~~participant's~~] eligible recipient's health and safety in the home or the community; are likely to lead to incarceration or admission to a hospital, NF or ICF/MR; require intensive intervention or medication management by a doctor or [~~mental health~~] behavioral health

practitioner or care practitioner; and cannot be effectively addressed within the AAB or other resources, including natural supports, the medicaid state plan, medicare or other sources;

(i) examples of chronic or intermittent behaviors or cognitive difficulties are that the [~~participant~~] eligible recipient injuries him/herself frequently or seriously; has uncontrolled physical aggression toward others; disrupts most activities to the extent that his/her SSP cannot be implemented or routine activities of daily living cannot be carried out; withdraws personally from contact with most others; leaves or wanders away from the home, work or service delivery environment in a way that puts him/herself or others at risk;

(ii) the [~~participant~~] eligible recipient must submit a written dated and signed evaluation or letter from a medical doctor, doctor of osteopathy, certified nurse practitioner, physician's assistant, psychiatrist or psychologist with a doctorate of psychology that documents the [~~participant's~~] eligible recipient's [~~mental health~~] or behavioral health status relevant to the criteria; if the need for additional budgetary allotment is identified during the LOC assessment, it must be reflected in the assessment; if there has been a change in the [~~participant's~~] eligible recipient's behaviors or cognitive difficulties, additional documentation is required; with a change in the [~~participant's~~] eligible recipient's behavior or cognitive difficulties, the evaluation or letter must have been completed since the last LOC assessment or less than one year from the date the request is submitted, whichever is more recent;

(iii) the [~~participant~~] eligible recipient may submit additional supportive documentation including a current individual service plan if the [~~participant~~] eligible recipient is transferring from another waiver, a positive behavioral support plan or assessment, recent notes, a summary or letter from a [~~mental~~] behavioral health practitioner or professional with expertise in developmental disabilities, brain injury or geriatrics, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other support individuals involved with the [~~participant~~] eligible recipient;

(d) change in natural supports: the [~~participant~~] eligible recipient has experienced a loss, as a result of situations such as death, illness, or disabling condition, of his/her natural supports, such as family members or other community resources that were providing direct care or services, whether paid or not; this absence of natural supports or other resources is expected to continue throughout the period for which supplemental funds are requested; the type, intensity or amount of care or services previously provided by natural supports or other resources cannot be acquired within the IBA and are not available through the medicaid state plan, medicare, other programs or sources in order for the [~~participant~~] eligible recipient to live in a home and community-based setting.

(4) A mi via [~~participant~~] eligible recipient is responsible for tracking all budget expenditures and assuring that all expenditures are within the AAB. The [~~participant~~] eligible recipient must not exceed the AAB within any SSP year. [~~A participant's~~] The eligible recipient's failure to properly allocate the expenditures within the SSP year resulting in the depletion of the AAB, due to mismanagement of or failure to track the funds, prior to the calendared expiration date does not substantiate a claim for a budget increase (i.e, if all of the AAB is expended within the first three months of the SSP year, it is not justification for an increase in the annual budget for that SSP year). Amendments to the AAB may occur within the SSP year and the [~~participant~~] eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. Amendments to the AAB must be preceded by an amendment to the SSP.

(5) The AAB may be revised once the original annual budget request has been submitted and approved. Only one annual budget revision request may be submitted at a time, e.g., an annual budget revision request may not be submitted if a prior annual budget revision request is under initial review by the TPA. The same requirement also applies to any [~~re-review or~~] reconsideration of the same revision request.

G. **SSP and annual budget supports:** As specified in the mi via program [~~regulations~~] rules and service standards, the mi via [~~participant~~] eligible recipient is assisted by the consultant in development and implementation of the SSP and AAB. The FMA assists the [~~participant~~] eligible recipient with implementation of the AAB.

H. **Submission for approval:** The TPA must approve the SSP and associated annual budget request (resulting in an AAB). The TPA must approve certain changes in the SSP and annual budget request, as specified in the mi via program rules and service standards and in accordance with 8.302.5 NMAC, *Prior Authorization and Utilization Review*.

(1) At any point during the SSP and associated annual budget utilization review process, the TPA may request additional documentation from the[~~participant~~] eligible recipient. This request must be in writing and submitted to both the [~~participant~~] eligible recipient and the consultant provider. The [~~participant~~] eligible recipient has 15-working days from the date of the request to respond to the request for additional documentation. Failure by the [~~participant~~] eligible recipient to submit the requested information may subject the SSP and annual budget request to denial.

(2) Services cannot begin and goods may not be purchased before the start date of the approved SSP and AAB or approved revised SSP and revised AAB.

(3) Any revisions requested for other than critical health or safety reasons within 60 calendar days of expiration of the SSP and AAB are subject to denial for that reason.

[8.314.6.17 NMAC - Rp, 8.314.6.17 NMAC, 4-1-11; A, 4-1-12]

8.314.6.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services, including services covered under this waiver, are subject to utilization review for medical necessity and program requirements. Reviews by HSD/MAD or its designees may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made in accordance with 8.302.5 NMAC, *Prior Authorization and Utilization Review*.

A. **Prior authorization:** Services, supports, and goods specified in the SSP and AAB require prior authorization from HSD/MAD or its designee. The SSP must specify the type, amount and duration of services. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** To be eligible for mi via program services, [~~participants~~] eligible recipients must require the LOC of services provided in an ICF-MR for [~~participants~~] eligible recipients identified as DD and MF, or in an NF for participants identified as CoLTS (c), diagnosed with AIDS, or BI. Prior authorization of services does not guarantee that [~~applicants/participants~~] applicants/eligible recipients are eligible for medicaid.

C. **Reconsideration:** If there is a disagreement with a prior authorization denial or other review decision, the consultant provider on behalf of the [~~participant~~] eligible recipient, can request a reconsideration from the TPA that performed the initial review and issued the initial decision. A reconsideration must be requested within 30-calendar days of the date on the denial notice. Reconsideration requests must be in writing and provide additional documentation or clarifying information regarding the [~~participant's~~] eligible recipient's request for the denied services or goods.

D. **Denial of payment:** If a service, support, or good is not covered under the mi via program, the claim for payment may be denied by HSD/MAD or its designee. If it is determined that a service is not covered before the claim is paid, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

[8.314.6.18 NMAC - Rp, 8.314.6.18 NMAC, 4-1-11; A, 7-1-12]

8.314.6.19 REIMBURSEMENT:

A. Mi via [~~participants~~] eligible recipients must follow all billing instructions provided by the FMA to ensure payment of service providers and vendors.

B. Claims must be billed to the FMA per the billing instructions. Reimbursement to service providers and vendors in the mi via program is made, as follows:

(1) mi via service providers and vendors must enroll with the FMA;

(2) mi via [~~participants~~] eligible recipients receive instructions and documentation forms necessary for service providers' and vendors' claims processing;

(3) mi via [~~participants~~] eligible recipients must submit claims for payment of mi via service providers and vendors to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;

(4) mi via [~~participants~~] eligible recipients and mi via service providers and vendors must follow all FMA billing instructions [~~and those contained in 8.302 NMAC~~]; and

(5) reimbursement of mi via service providers and vendors is made at a predetermined reimbursement rate negotiated by the [~~participant~~] eligible recipient with the service provider or vendor, approved by the TPA contractor, and documented in the SSP and in the provider/vendor agreement; at no time can the total expenditure for services exceed the [~~participant's~~] eligible recipients AAB.

C. The FMA must submit claims that have been paid by the FMA on behalf of mi via [~~participant~~] eligible recipient to the HSD/MAD fiscal contractor for processing.

D. Reimbursement may not be made directly to the [~~participant~~] eligible recipient, either to reimburse him/her for expenses incurred or to enable the [~~participant~~] eligible recipient to pay a service provider directly.

[8.314.6.19 NMAC - Rp, 8.314.6.19 NMAC, 4-1-11; A, 7-1-12]

8.314.6.20 RIGHT TO A HEARING:

A. The HSD/MAD must grant an opportunity for an administrative hearing as described in this section in the following circumstances and pursuant to 42 CFR Section 431.220(a)(1) and (2), NMSA 1978, Section 27-3-3 and 8.352.2 NMAC *Recipient Hearings*:

(1) when a mi via applicant has been determined not to meet the LOC requirement for waiver services;

(2) when a mi via applicant has not been given the choice of HCBS as an alternative to institutional care;

(3) when a mi via applicant is denied the services of his/her choice or the provider of his/her choice;

(4) when a mi via [~~participant~~'s eligible recipient's services are denied, suspended, reduced or terminated;

(5) when a mi via [~~participant~~] eligible recipient has been involuntarily terminated from the program;

(6) when a mi via [~~participant's~~] eligible recipient's request for a budget adjustment has been denied.

B. DOH and its counsel, if necessary, shall participate in any fair hearing involving a DD or MF [~~participant~~] eligible recipient, or [~~a participant~~] an eligible recipient diagnosed with AIDS. HSD/MAD, and its counsel, if necessary, may participate in fair hearings.

[8.314.6.20 NMAC - N, 4-1-11; A, 4-1-12; A, 7-1-12]

8.314.6.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to [~~participants~~] eligible recipients who request a hearing within 13 calendar days of the notice. The notice will include information on the right to continued benefits and on the [~~participant's~~] eligible recipient's responsibility for repayment if the hearing decision is not in the [~~participant's~~] eligible recipient's favor.

B. Once [~~a participant~~] the eligible recipient requests a continuation of benefits, his/her current AAB and SSP [~~that is in place~~] at the time of the request is termed a [~~continuation budget~~] 'continuation f benefits'. The continuation budget may not be revised until the conclusion of the fair hearing process unless one of the criteria to modify the budget in Paragraph (3) of Subsection F of 8.314.6.17 NMAC is met.

[8.314.6.21 NMAC - N, 4-1-11; A, 7-1-12]

8.314.6.22 GRIEVANCE/COMPLAINT SYSTEM: HSD/MAD and DOH operate a grievance/complaint system that affords [~~participant's~~] eligible recipient's the opportunity to register grievances or complaints concerning the provision of services under the mi via program. HSD/MAD administers the grievance/complaint process for [~~participant's~~] eligible recipient's in the mi via NF LOC waiver who are brain injured or disabled [~~and~~] or elderly. DOH administers the grievance/complaint process for [~~participants~~] eligible recipients in the ICF/MR level of care (LOC) waiver and for [~~participants~~] eligible recipients in the AIDS program who are in the NF LOC waiver. [~~Participants~~] Eligible recipients may register complaints with either department via e-mail, mail or phone. Complaints will be referred to the appropriate department for resolution. The [~~participant~~] eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.

A. A grievance or complaint is required to be [~~resolved~~] addressed within 30 calendar days from the date it was received.

B. Upon receipt of the grievance or complaint, DOH or HSD/MAD enters it into the complaint tracker and informs the contractor or provider of the grievance or complaint. DOH or HSD/MAD notifies the [~~participant~~] eligible recipient within one day of receipt of the grievance or complaint who will be responsible for resolution of the grievance or complaint.

C. DOH or HSD/MAD gives the contractor or provider 14 calendar days to resolve the grievance or complaint. If the grievance or complaint contains an issue that may compromise the health or safety of the participant, DOH or HSD/MAD remains involved with the parties until the grievance or complaint is resolved.

D. The contractor or provider shall notify DOH or HSD/MAD of their progress toward resolution of the grievance or complaint. If the grievance or complaint has not been resolved in 14 calendar days, DOH or HSD/MAD becomes involved to ensure that [~~a~~] an initial response is issued within 30 calendar days of receipt of the grievance or complaint.

[8.314.6.22 NMAC - N, 4-1-11; A, 4-1-12; A, 7-1-12]