State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT

NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD)

II. SUBJECT

MANAGED CARE PROGRAM RULES
8.308.9 NMAC, BENEFIT PACKAGE, 8.308.12 NMAC, COMMUNITY BENEFIT PACKAGE, 8.308.13 NMAC, MEMBER REWARDS AND 8.308.14, COST SHARING.

III. PROGRAM AFFECTED

(TITLE XIX) MEDICAID

IV. ACTION

PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department (the Department), through the Medical Assistance Division (MAD), is proposing Managed Care benefit and service rules in preparation for the implementation of Centennial Care. The proposed managed care benefit package rule includes services available to an Alternative Benefit Plan member, as well as for a Managed Care Medicaid member.

8.308.9	Benefit Package
8.308.12	Community Benefit Package
8.308.13	Member Rewards
8.308.14	Cost Sharing

VI. RULES

These proposed rules will be contained in 8.308.9 NMAC, 8.308.12 NMAC, 8.308.13 NMAC, and 8.308.14 NMAC. This register and the proposed rules are available on the MAD website at http://www.hsd.state.nm.us/mad/registers/2013. If you do not have internet access, a copy of the proposed rules may be requested by contacting MAD at 505-827-3152.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective January 1, 2014.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at the Rio Grande Conference Room, Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, NM on Friday, December 6, 2013 at 8:30 am.

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 MAD toll free at 1-888-997-2583 and ask for extension 7-3152. In Santa Fe, call 827-3152. 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 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available on December 23, 2013 by MAD 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

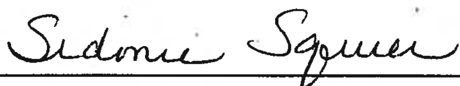
Interested persons may address written or recorded comments to:

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 p.m. on December 6, 2013. Written and recorded comments will be given the same consideration as testimony made at the public hearing. Interested persons may address comments via telephone to 505-827-3152 or via electronic mail to: Emily.Floyd@state.nm.us.

X. PUBLICATION

Publication of these rules approved by:



SIDONIE SQUIER, SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 9 BENEFIT PACKAGE

8.308.9.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.9.1 NMAC - N, 1-1-14]

8.308.9.2 SCOPE: This rule applies to the general public.
[8.308.9.2 NMAC - N, 1-1-14]

8.308.9.3 STATUTORY AUTHORITY: 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 Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.9.3 NMAC - N, 1-1-14]

8.308.9.4 DURATION: Permanent.
[8.308.9.4 NMAC - N, 1-1-14]

8.308.9.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.9.5 NMAC - N, 1-1-14

8.308.9.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.9.6 NMAC - N, 1-1-14]

8.308.9.7 DEFINITIONS:

A. Alternative benefits plan services with limitations (ABP): The medical assistance division (MAD) category of eligibility "other adults" has an alternative benefit plan (ABP). The HSD contracted managed care organization (MCO) covers ABP specific services for an ABP member. Services are made available through MAD under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member has limitations on specific benefits; and does not have all MCO medicaid benefits available. All early and periodic screening, diagnosis and treatment (EPSDT) program services are available to an ABP member under 21 years. ABP services for an ABP member under the age of 21 years not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. A MCO ABP contracted provider and an ABP member have rights and responsibilities as described in chapter 308 of Title 8 Social Services NMAC.

B. Alternative benefits plan general benefits for ABP exempt member (ABP exempt): An ABP member who self-declares he or she has a qualifying condition is evaluated by the MCO's utilization management for determination if he or she meets the qualifying condition. An ABP exempt member utilizes his or her benefits described in this rule and in 8.308.12 NMAC. Mi Via is not available to an ABP exempt member.
[8.308.9.7 NMAC - N, 1-1-14]

8.308.9.8 MISSION STATEMENT: 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.
[8.308.9.8 NMAC - N, 1-1-14]

8.308.9.9 BENEFIT PACKAGE: This part defines the benefit package for which an MCO shall be paid a fixed per-member-per-month capitated payment rate. The MCO shall cover the services specified in this rule. The MCO shall not delete a benefit from the MCO benefit package. A MCO is encouraged to provide a value added benefit package which could include health-related educational, preventive, outreach and other physical and behavioral health benefits. The MCO may utilize providers licensed in accordance with state and federal requirements to deliver services. The MCO shall provide and coordinate comprehensive and integrated health care benefits to each enrolled member in either a MCO medicaid or MCO ABPmember and shall cover the physical health, behavioral health and long-term care services per this section, its contract, and as directed. If the MCO is unable to provide covered services to a particular member using one of its contracted providers, the MCO shall

adequately and timely cover these services for that member using a non-contract provider for as long as the member's MCO provider network is unable to provide the service. At such time that the required services become available within the MCO's network and the member can be safely transferred, the MCO may transfer the member to an appropriate contract provider according to a transition of care plan developed specifically for the member; see 8.308.11 NMAC.
[8.308.9.9 NMAC - N, 1-1-14]

8.308.9.10 MEDICAL ASSISTANCE DIVISION PROGRAM RULES: MAD New Mexico administrative code (NMAC) rules and related documents contain a detailed description of the services covered by MAD, the limitations and exclusions to covered services, and noncovered services. The MAD NMAC rules are the official source of information on covered and noncovered services. Unless otherwise directed, the MCO shall determine its own utilization management (UM) protocols, which are based on reasonable medical evidence and are not bound by those found in the MAD NMAC rules, billing instructions or utilization review instructions. MAD may review and approve the MCO's UM protocols. Unless otherwise directed by MAD, a HSD contracted MCO is not required to follow MAD's reimbursement methodologies or MAD's fee schedules unless otherwise required in a MAD NMAC rule.
[8.308.9.10 NMAC - N, 1-1-14

8.308.9.11 GENERAL PROGRAM DESCRIPTION:

A. The MCO shall provide medically necessary services consistent with the following:

(1) a determination that a health care service is medically necessary does not mean that the health care service is a covered service. Benefits are to be determined by HSD;

(2) in making the determination of medical necessity of a covered service the MCO shall do so by:

(a) evaluating the member's physical and behavioral health information provided by the a qualified professional who has personally evaluated the member within his or her scope of practice; who have taken into consideration the member's clinical history, including the impact of previous treatment and service interventions and who has consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the member or his or her authorized agent regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems;

(3) not denying physical, behavioral health and long-term care services solely because the member has a poor prognosis. Medically necessary services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible member solely because of his or her diagnosis, type of illness or condition;

(4) governing decisions regarding benefit coverage for a member under 21 years of age by the EPSDT program coverage rule to the extent they are applicable; and

(5) making services available 24 hours, seven days a week, when medically necessary and are a MAD covered service.

B. The MCO shall meet all HSD requirements related to the anti-gag requirement. The MCO shall meet all HSD requirements related to advance directives. This includes but is not limited to:

(1) providing a member or his or her authorized agent with written information on advance directives that include a description of applicable state and federal law and regulation, the MCO's policy respecting the implementation of the right to have an advance directive, and that complaints concerning noncompliance with advance directive requirements may be filed with HSD. The information must reflect changes in federal and state statute, regulation or rule as soon as possible, but no later than 90 calendar days after the effective date of such a change;

(2) honoring advance directives within its UM protocols; and

(3) ensuring that a member is offered the opportunity to prepare an advance directive and that, upon request, the MCO provides assistance in the process.

C. The MCO shall allow second opinions: A member or his or her authorized representative shall have the right to seek a second opinion from a qualified health care professional within his or her MCO's network, or the MCO shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested when the member or his or her authorized agent needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.

D. The MCO shall meet all care coordination requirement set forth in Section 10 of this rule.
[8.308.9.11 NMAC - N, 1-1-14

8.308.9.12 GENERAL COVERED SERVICES:

A. **Ambulatory surgical services:** The benefit package includes surgical services rendered in an ambulatory surgical center setting as detailed in 8.324.10 NMAC.

B. **Anesthesia services:** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures as detailed 8.310.2 NMAC.

C. **Audiology services:** The benefit package includes audiology services as detailed in 8.310.2 and 8.324.5 NMAC with some limitations. For a ABP member 21 years and older, audiology services are limited to hearing testing or screening when part of a routine health exam and are not covered as a separate service. Audiology services, hearing aids and other aids are not covered.

D. **Client transportation:** The benefit package covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MCO member in or out of his or her home community as detailed in 8.310.2 NMAC.

E. **Community intervener:** The benefit package includes community intervener services. The community intervener works one-on-one with a deaf-blind member who is five-years of age or older to provide critical connections to other people and his or her environment. The community intervener opens channels of communication between the member and others, provides access to information, and facilitates the development and maintenance of self-directed independent living.

(1) Member eligibility: To be eligible for community intervener services, a member must be five-years of age or older and meet the clinical definition of deaf-blindness, defined as:

(a) the member has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;

(b) the member has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification or the progressive hearing loss having a prognosis leading to this condition; and

(c) the member for whom the combination of impairments described above cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

(2) Provider qualifications: The minimum provider qualifications for a community intervener are as follows:

(a) is at least 18 years of age;

(b) is not the spouse of the member to whom the intervener is assigned;

(c) holds a high school diploma or a high school equivalency certificate;

(d) has a minimum of two years of experience working with individuals with developmental disabilities;

(e) has the ability to proficiently communicate in the functional language of the deaf-blind member to whom the intervener is assigned; and

(f) completes an orientation or training course by any person or agency who provides direct care services to deaf-blind individuals.

F. **Dental services:** The benefit package includes dental services as detailed in 8.310.2 NMAC.

G. **Diagnostic imaging and therapeutic radiology services:** The benefit package includes medically necessary diagnostic imaging and radiology services as detailed in 8.310.2 NMAC.

H. **Dialysis services:** The benefit package includes medically necessary dialysis services as detailed in 8.310.2 NMAC. A dialysis provider shall assist a member in applying for and pursuing final medicare eligibility determination.

I. **Durable medical equipment and medical supplies:** The benefit package includes covered vision appliances, hearing aids and related services and durable medical equipment and medical supplies and covered prosthetic and orthotic services as detailed in 8.324.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

J. **Emergency and non-emergency transportation services:**

(1) The benefit package includes transportation service such as ground ambulance and air ambulance in an emergency and when medically necessary, and taxicab and handivan, commercial bus, commercial air, meal and lodging services as indicated for medically necessary physical and behavioral health services, as detailed in 8.324.7 NMAC. Non-emergency transportation is covered only when a member does not have a source of

transportation available and the member does not have access to alternative free sources. The MCO shall coordinate efforts when providing transportation services for a member requiring physical or behavioral health services.

(2) The benefit package also includes non-medical transportation as detailed in 8.314.5 NMAC.

L. **Experimental or investigational services:** The benefit package includes medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD as detailed in 8.310.2 NMAC.

M. **Home health services:** The benefit package includes home health services as detailed in 8.325.9 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

N. **Hospice services:** The benefit package includes hospice services as detailed in 8.325.4 NMAC. For an ABP eligible recipient 21 years of age and older, hospice services are limited to a $10,000 lifetime benefit.

O. **Hospital outpatient service:** The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative or palliative medical or behavioral health services as detailed in 8.311.2 NMAC.

P. **Inpatient hospital services:** The benefit package includes hospital inpatient acute care, procedures and services for the member as detailed in 8.311.2 NMAC. The MCO shall comply with the maternity length of stay in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Coverage for a hospital stay following a normal, vaginal delivery may not be limited to less than 48 hours for both the member and her newborn child. Health coverage for a hospital stay in connection with childbirth following a caesarian section may not be limited to less than 96 hours for the member and her newborn child.

Q. **Laboratory services:** The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA) as detailed in 8.310.2 NMAC.

P. **Nursing facility services:** The benefit package includes nursing facility services as detailed in 8.312.2 NMAC.

R. **Physical health services:** The benefit package includes primary, primary care in a school-based setting, and specialty physical health services provided by a licensed practitioner performed within the scope of practice; see 8.310.2 and 8.310.3 NMAC. Benefits also include an out of hospital birth and other related birthing services performed by a certified nurse midwife or a direct-entry midwife licensed by the state of New Mexico, who is either validly contracted with and fully credentialed by the MCO or validly contracted with HSD and participates in MAD birthing options program as detailed in 8.310.2 NMAC.

(1) The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology.

(2) The MCO shall participate in MAD's birthing options program.

S. **Prosthetics and orthotics:** The benefit package includes prosthetic and orthotic services as detailed in 8.324.5 NMAC.

T. **Rehabilitation services:** The benefit package includes inpatient and outpatient hospital, and outpatient physical, occupational and speech therapy services as detailed in 8.323.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations

U. **Private duty nursing:** The benefit package includes private duty nursing services for a member 21 years and older. The benefit package also includes private duty nursing for the adult population as detailed in 8.325.9 NMAC.

V. **Swing bed hospital services:** This benefit package includes services provided in hospital swing beds to a member expected to reside in such a facility on a long-term or permanent basis as defined in 8.311.5 NMAC.

W. **Tobacco cessation services:** The benefit package includes cessation sessions as described in 8.310.2 NMAC and education.

X. **Transplant services:** 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 detailed in 8.310.2 NMAC. See 8.325.6 NMAC for guidance whether MAD has determined if a transplant is experimental or investigational.

Y. **Nutrition services:** The benefit package includes nutritional services based on scientifically validated nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the member as detailed in 8.310.2 NMAC.

Z. **Podiatry:** The benefit package includes podiatric services furnished by a provider, as required by the condition of the member as detailed in 8.310.2 NMAC.

AA. **Vision and eye care services:** The benefit package includes specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a member as detailed in 8.310.2 NMAC. All services must be furnished within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules. For an ABP eligible recipient 21 years and older, the service limitations are listed below:

(1) coverage is limited to one routine eye exam in a 36-month period.

(2) MAD does not cover the correction of refractive errors required by the condition of the ABP eligible recipient.

BB. **Other services:** When an additional benefit service is approved by MAD, the MCO shall cover that service as well.

[8.308.9.12 NMAC - N, 1-1-14]

8.308.9.13 SPECIFIC CASE MANAGEMENT PROGRAMS: The benefit package includes case management services necessary to meet an identified service need of a member. The following are specific case management programs available when a member meets the requirements of a specific service.

A. **Case management services for adults with developmental disabilities:** Case management services are provided to a member 21 years of age and older who is developmentally disabled as detailed in 8.326.2 NMAC.

B. **Case management services for pregnant women and their infants:** Case management services are provided to a member who is pregnant up to 60 calendar days following the end of the month of the delivery as detailed in 8.326.3 NMAC.

C. **Case management services for traumatically brain injured adults:** Case management services are provided to a member 21 years of age and older who is traumatically brain injured as detailed in 8.326.5 NMAC.

D. **Case management services for children up to the age of three:** Case management services for a member up to the age of three years who is medically at-risk due to family conditions and who does not have a developmental delay as detailed in 8.326.6 NMAC.

E. **Case management services for the medically at risk (EPSDT):** Case management services for a member under 21 years of age who is medically at-risk for a physical or behavioral health condition as detailed in 8.320.2 NMAC.

[8.308.9.13 NMAC - N, 1-1-14]

8.308.9.14 PHARMACY SERVICES: The benefit package includes pharmacy and related services, as detailed in 8.324.4 NMAC.

A. The MCO may determine its formula for estimating acquisition cost and establishing pharmacy reimbursement. The MCO must comply with the provisions of NMSA 1978, 27-2-16(B). Specifically, the MCO must base its formula for estimation of acquisition cost and reimbursement on regulations promulgated and published by HSD regarding the wholesale cost for the ingredient component of pharmacy reimbursement.

B. The MCO shall include on the MCO's 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 that are not medically necessary and as otherwise approved by MAD. Cough, cold and allergy medications must be covered but all multi-source generic products do not need to be covered. This requirement does not preclude a MCO from requiring authorization prior to dispensing a multi-source generic item.

C. The MCO is not required to cover all multi-source generic over-the-counter items. Coverage of over-the-counter items may be restricted to instances for which a practitioner has written a prescription, and for which the item is an economical or preferred therapeutic alternative to the prescribed item.

D. The MCO shall cover brand name drugs and drug items not generally on the MCO formulary or PDL when determined to be medically necessary by the MCO or through a fair hearing process.

E. Unless otherwise approved by MAD, the MCO shall have an open formulary for all psychotropic medications. Minor tranquilizers, sedatives, and hypnotics are not considered psychotropic medications for the purpose of this rule.

F. MCO shall ensure that a native American member accessing the pharmacy benefit at an Indian health service (IHS), tribal, and urban Indian (I/T/U) facility is exempt from the MCO's PDL when these pharmacies have their own PDL.

G. The MCO shall reimburse family planning clinics, school-based health clinics (SBHCs) and the department of health (DOH) public health clinics for oral contraceptive agents and plan B when dispensed to a member and billed using healthcare common procedure coding (HCPC) codes and CMS 1500 forms.

H. The MCO shall meet all federal and state requirements related to pharmacy rebates and submit all necessary information as directed by HSD.

I. When directed and approved by MAD, the MCO shall follow all contractual and MAD NMAC rules as they relate to the co-payment for legend drugs when a generic is available.

(1) The MCO shall impose the maximum nominal co-payment established by HSD in accordance with federal regulations on any prescription filled for its member with a brand name drug when a therapeutically equivalent generic drug is available unless the brand name drug will provide better therapeutic response or will have fewer adverse effects for the member. This co-payment shall not apply to brand name drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions.

(2) The MCO shall not impose any co-payments on native Americans.

[8.308.9.14 NMAC - N, 1-1-14]

8.308.9.15 EARLY AND PEDIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICES (EPSDT): The benefit package includes the delivery of the federally mandated EPSDT services [42 CFR Section 441.57] provided by a primary care provider (PCP) as detailed in 8.320.2 NMAC. The MCO shall provide access to early intervention programs and services for a member identified in an EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder. Unless otherwise specified in a service rule, EPSDT services are for a member under 21 years of age. For detailed description of each service, see 8.320.2 NMAC. EPSDT behavioral health services are included in Section 19 of this rule.

A. **EPSDT nutritional counseling and services:** The benefit package includes nutritional services furnished to a pregnant member and a member under 21 years of age as detailed in 8.310.2 NMAC.

B. **EPSDT personal care:** The benefit package includes personal care services for a member.

C. **EPSDT private duty nursing:** The benefit package includes private duty nursing for a member and the services shall be delivered in either his or her home or school setting.

D. **EPSDT rehabilitation services:** A member under 21 years of age who is eligible for home and community based waiver services receives medically necessary rehabilitation services through the EPSDT program; see 8.320.2 NMAC for a detailed description. The home and community-based waiver program provides rehabilitation services only for the purpose of community integration.

E. **Services provided in schools:** The benefit package includes services to a member provided in a school, excluding those specified in his or her individual education plan (IEP) or the individualized family service plan (IFSP); see 8.320.6 NMAC.

F. **Tot-to-teen health checks:** The MCO shall adhere to the periodicity schedule and ensure that the member receives EPSDT screens (tot-to-teen health checks). The services include the following with respect to treatment follow-up:

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

(2) development of a proactive approach to ensure that the member receives the services;

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

(4) development of a systematic communication process with MCO network providers regarding screens and treatment coordination;

(5) processes to document, measure and assure compliance with the periodicity schedule; and

(6) development of a proactive process to insure the appropriate follow-up evaluation, referral and treatment, including early intervention for vision and hearing screening, dental examinations and current immunizations. The MCO will facilitate appropriate referral for possible or identified behavioral health conditions. See 8.321.2 NMAC for EPSDT behavioral health services descriptions.

[8.308.9.15 NMAC - N, 1-1-14]

8.308.9.16 REPRODUCTIVE HEALTH SERVICES: The benefit package includes reproductive health services as detailed in 8.310.2 NMAC. The MCO shall implement written policies and procedures approved by HSD which define how a member is educated about his or her rights to family planning services, freedom of choice, to include access to non-contract providers, and methods for accessing family planning services.

A. The family planning policy shall ensure that a member of the appropriate age of both sexes who seeks family planning services shall be provided with counseling pertaining to the following:

(1) human immunodeficiency virus (HIV) and other sexually transmitted diseases and risk reduction practices; and

(2) birth control pills and devices (including plan B).

B. The MCO shall provide a member with sufficient information to allow him or her to make informed choices including the following:

(1) types of family planning services available;

(2) the member's right to access these services in a timely and confidential manner;

(3) freedom to choose a qualified family planning provider who participates in the MCO network or from a provider who does not participate in the member's MCO network; and

(4) if a member chooses to receive family planning services from a non-contracted provider, the member shall be encouraged to exchange medical information between the PCP and the non-contracted provider for better coordination of care.

C. **Pregnancy termination procedures:** The benefit package includes services for the termination of a pregnancy as detailed in 8.310.2 NMAC. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 441.202 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.310.2 NMAC.
[8.308.9.16 NMAC - N, 1-1-14]

8.308.9.17 PREVENTIVE PHYSICAL HEALTH SERVICES: The MCO shall follow current national standards for preventive health services, including behavioral health preventive services. Standards are derived from several sources, including the U.S. preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Any preventive health guidelines developed by the MCO under these standards shall be adopted and reviewed at least every two years, updated when appropriate and disseminated to its practitioners and members. Unless a member refuses and the refusal is documented, the MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access care.

A. Initial assessment: The MCO shall conduct a health risk assessment (HRA), per HSD guidelines and processes, for the purpose of introducing the MCO to the member, obtaining basic health and demographic information about the member, assisting the MCO in determining the LOC coordination needed by the member, and determining the need for a NF LOC assessment.

B. **Family planning:** The MCO must have a family planning policy. This policy must ensure that a member of the appropriate age of both sexes who seeks family planning services is provided with counseling and treatment, if indicated, as it relates to the following:

(1) methods of contraception; and

(2) HIV and other sexually transmitted diseases and risk reduction practices.

C. **Guidance:** The MCO shall adopt policies that shall ensure that an applicable asymptomatic member is provided guidance on the following topics unless the member's refusal is documented:

(1) prevention of tobacco use;

(2) benefits of physical activity;

(3) benefits of a healthy diet;

(4) prevention of osteoporosis and heart disease in a menopausal member citing the advantages and disadvantages of calcium and hormonal supplementation;

(5) prevention of motor vehicle injuries;

(6) prevention of household and recreational injuries;

(7) prevention of dental and periodontal disease;

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

(9) prevention of an unintended pregnancy; and

(10) prevention or intervention for obesity or weight issues.

D. **Immunizations:** The MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, a member is immunized according to the type and schedule provided by current recommendations of the state department of health (DOH). The MCO shall encourage providers to verify and document all administered immunizations in the New Mexico statewide immunization information system (SIIS).

E. **Nurse advice line:** The MCO shall provide a toll-free clinical telephone nurse advice line function that includes at least the following services and features:

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

(2) pre-diagnostic and post-treatment health care decision assistance based on the member's symptoms.

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

(1) educational outreach to a member of childbearing age;

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

(3) risk assessment of a pregnant member to identify high-risk cases for special management;

(4) counseling which strongly advises voluntary testing for HIV;

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

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

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

G. **Screens:** The MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, each asymptomatic member receives at least the following preventive screening services listed below.

(1) *Screening for breast cancer*: A female member between the ages of 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Blood pressure measurement*: A member 18 years of age or older shall receive a blood pressure measurement at least every two years.

(3) *Screening for cervical cancer*: A female member with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age and every three years thereafter until reaching 65 years of age when prior testing has been consistently normal and the member has been confirmed not to be at high risk. If the member is at high risk, the frequency shall be at least annual.

(4) *Screening for chlamydia*: All sexually active female members 25 years of age and younger shall be screened for chlamydia. All female members over 25 years of age shall be screened for chlamydia if they inconsistently use barrier contraception, have more than one sex partner, or have had a sexually transmitted disease in the past.

(5) *Screening for colorectal cancer*: A member 50 years of age and older, who is at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy or double contrast barium at a periodicity determined by the MCO.

(6) *Screening for elevated lead levels*: A member between 9-15 months (ideally at 12 months) shall receive a blood lead measurement at least once. A member at one (1) and at two (2) years of age shall receive a blood lead measurement. A member between the ages of 3 to 6 years, for whom no previous test exists, should also be tested.

(7) *Newborn screening*: A newborn member shall be screened for those disorders specified in the state of New Mexico metabolic screen.

(8) *Screening for obesity*: A member shall receive body weight, height and length measurements with each physical exam. A member under 21 years of age shall receive a BMI percentile designation.

(9) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, D(Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the American college of obstetricians and gynecologists.

(10) *Screening for rubella*: All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(11) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk members shall be screened or previous screenings noted:

(a) a member who has immigrated from countries in Asia, Africa, latin America or the middle east in the preceding five years;

(b) a member who has substantial contact with immigrants from those areas; a member who is a migrant farm worker;

(c) a member who is an alcoholic, homeless or is an injecting drug user. HIV-infected persons shall be screened annually; and

(d) a member whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local DOH public health office in his or her community of residence for contact investigation.

(12) *Serum cholesterol measurement*: A male member 35 years and older and a female member 45 years and older who is at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. A member 20 years and older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements annually.

(13) *Tot-to-teen health checks*: The MCO shall operate the tot-to-teen mandated EPSDT program as outlined in 8.320.2 NMAC. Within three months of enrollment lock-in, the MCO shall ensure that the member is current according to the screening schedule, unless more stringent requirements are specified in these standards. The MCO shall encourage its PCPs to assess and document for age, height and gender appropriate weight and for body mass index (BMI) percentage during EPSDT screens to detect and treat evidence of weight or obesity issues in members under 21 years of age.

(14) *Screening for type 2 diabetes*: A member with one or more of the following risk factors for diabetes shall be screened. Risk factors include:

(a) a family history of diabetes (parent or sibling with diabetes); obesity (>20% over desired body weight or BMI >27kg/m2);

(b) race or ethnicity (e.g. hispanic, native American, African American, Asian-Pacific islander);

(c) previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (>140/90 mmHg); HDL cholesterol level <35 mg/dl and triglyceride level >250 mg/dl; history of gestational diabetes mellitus (GDM); and

(d) a delivery of newborn over nine pounds.

(15) A member 21 years of age and older must be screened to detect high risk for behavioral health conditions at his or her first encounter with a PCP after enrollment.

(16) The MCO shall require its PCPs to refer a member, whenever clinically appropriate, to behavioral health provider, see 8.321.2 NMAC. The MCO shall assist the member with an appropriate behavioral health referral.

[8.308.9.17 NMAC - N, 1-1-14]

8.308.9.18 TELEMEDICINE SERVICES: The benefit package includes telemedicine services as detailed in 8.310.2 NMAC.

A. The MCO must:

(1) promote and employ broad-based utilization of statewide access to Health Insurance Portability and Accountability Act (HIPAA)-compliant telemedicine service systems including, but not limited to, access to text telephones or teletype (TTYs) and 711 telecommunication relay services;

(2) follow state guidelines for telemedicine equipment or connectivity;

(3) follow accepted HIPAA and 42 C.F.R. part two regulations that affect telemedicine transmission, including but not limited to staff and contract provider training, room setup, security of transmission lines, etc. The MCO shall have and implement policies and procedures that follow all federal and state security and procedure guidelines;

(4) identify, develop, and implement training for accepted telemedicine practices;

(5) participate in the needs assessment of the organizational, developmental, and programmatic requirements of telemedicine programs;

(6) report to HSD on the telemedicine outcomes of telemedicine projects and submit the telemedicine report; and

(7) ensure that telemedicine services meet the following shared values, which are ensuring: competent care with regard to culture and language needs; work sites are distributed across the state, including native American sites for both clinical and educational purposes; and coordination of telemedicine and technical functions at either end of network connection.

B. The MCO shall participate in project extension for community healthcare outcomes (ECHO), in accordance with state prescribed requirements and standards, and shall:

(1) work collaboratively with HSD, the university of New Mexico, and providers on project ECHO;

(2) identify high needs, high cost members who may benefit from project ECHO participation;

(3) identify its PCPs who serve high needs, high cost members to participate in project ECHO;

(4) assist project ECHO with engaging its MCO PCPs in project ECHO's center for medicare and medicaid innovation (CMMI) grant project;

(5) reimburse primary care clinics for participating in the project ECHO model;

(6) reimburse "intensivist" teams;

(7) provide claims data to HSD to support the evaluation of project ECHO;
(8) appoint a centralized liaison to obtain prior authorization approvals related to project ECHO; and
(9) track quality of care and outcome measures related to project ECHO.
[8.308.9.18 NMAC - N, 1-1-14]

8.308.9.19 BEHAVIORAL HEALTH SERVICES:
A. The MCO shall cover the following behavioral health services listed below. When an additional behavioral health service is approved by MAD, the MCO shall cover that service as well. See 8.321.2 NMAC for detailed descriptions of each service. MAD makes available on its website its behavioral health service definitions and crosswalk, along with other information.

(1) **Applied behavior analysis:** The benefit package includes applied behavior analysis (ABA) services for a member three years of age up to 21 years of age who has a well-documented medical diagnosis of autism spectrum disorder (ASD), and for a member under 3 years of age who has a well-documented risk for the development of ASD. The need for ABA services must be identified in the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

(2) **Assertive community treatment services (ACT):** The benefit package includes assertive community treatment services for a member 18 years of age and older.

(3) **Behavioral health respite:** Behavioral health respite care is provided to a member under 21 years of age to support the member's family and strengthen their resiliency during the respite while the member is in a supportive environment. Respite care is provided to a member with a severe emotional disturbance who resides with his or her family and displays challenging behaviors that may periodically overwhelm the member's family's ability to provide ongoing supportive care. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines –respite services-for a detailed description.

(5) **Comprehensive community support services:** The benefit package includes comprehensive community support services for a member.

(4) **Family support services:** The benefit package includes family support services to a member whose focus is on the member and his or her family and the interactive effect through a variety of informational and supportive activities that assists the member and his or her family develop patterns of interaction that promote wellness and recovery over time. The positive interactive effect between the member and his or her family strengthens the effectiveness of other treatment and recovery initiatives. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines –family support services-for a detailed description.

(4) **Hospital outpatient services:** The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt unit of a general hospital for a member.

(5) **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.

(6) **Intensive outpatient (IOP) services:** The benefit package includes intensive outpatient services for a member 13 years of age.

(7) **Medication assisted treatment for opioid addiction:** The benefit package includes medication assisted treatment services for opioid addiction to a member through an opioid treatment center as defined in 42 CFR Part 8, *Certification of Opioid Treatment*.

(8) **Outpatient therapy services:** The benefit package includes outpatient therapy services (individual, family, and group) for a member.

(9) **Psychological rehabilitation services:** The benefit package includes adult psychosocial rehabilitation services for a member 18 years and older.

(10) **Recovery services:** The benefit package includes recovery services for a member. Recovery services are peer-to-peer support within a group setting to develop and enhance wellness and healthcare practices. The service enables a member to identify additional needs and goals and link him or herself to additional support as a result. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines –recovery services-for a detailed description.

B. **Behavioral health EPSDT services:** The benefit package includes the delivery of the federally mandated EPSDT services [42 CFR Section 441.57] provided by a behavioral health practitioner for a member under 21 years of age. See 8.321.2 NMAC for a detailed description of each service. The MCO shall provide access to EPSDT for a member identified in his or her EPSDT tot to teen health check screen or another diagnostic evaluation as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder.

(1) **Accredited residential treatment center (ARTC):** The benefit package includes services furnished in an ARTC furnished as part of the EPSDT program. ARTC services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for ARTC services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(2) **Behavior management skills development services (BMS):** The benefit package includes BMS services furnished as part of the EPSDT program. BMS services are provided to a member who has an identified need for such services and meets the required LOC. The need for BMS services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(3) **Day treatment services:** The benefit package includes day treatment services furnished as part of the EPSDT program. Day treatment services are provided to a member who has an identified need for such services and meets the required LOC. The need for day treatment services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(4) **Inpatient hospitalization services provided in freestanding psychiatric hospitals:** The benefit package includes inpatient psychiatric care furnished in a freestanding psychiatric hospital furnished as part of the EPSDT program. Inpatient hospitalization services are provided in a freestanding psychiatric hospital are provided to a member who has an identified need for such services and meet the required LOC. The need for such services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(5) **Multi-systemic therapy (MST):** The benefit package includes MST services furnished as part of the EPSDT program. MST services are provided to a member who has an identified need for such services and meets the required LOC. The need for MST services must be identified in the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

(6) **Psychosocial rehabilitation services (PSR):** The benefit package includes PSR services furnished as part of the EPSDT program. PSR is provided to a member who has an identified need for such services and meets the required LOC. The need for PSR services must be identified in the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

(7) **Treatment foster care I (TFC I):** The benefit package includes TFC I furnished as part of the EPSDT program. TFC I services are provided to a member who has an identified need for such services and meets the required LOC. The need for TFC I services must be identified in the member's tot to teen healthcheck or another diagnostic evaluation furnished through a healthcheck referral.

(8) **Treatment foster care II (TFC II):** The benefit package includes TFC II services furnished as part of the EPSDT program. TFC II is provided to a member who has an identified need for such services and meets the required LOC. The need for TFC II services must be identified in the member's tot to teen healthcheck or another diagnostic evaluation furnished through a healthcheck referral.

(9) **Residential non-accredited treatment center (RTC) and group home:** The benefit package includes services furnished in a RTC center or group home as part of the EPSDT program. RTC or group home services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for RTC and group home services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

[8.308.9.19 NMAC - N, 1-1-14]

8.308.9.20 COMMUNITY BENEFIT SERVICES: The MCO shall cover community benefit services for a member who meets the specific eligibility requirements for each MCO community benefit service as detailed in 8.308.12 NMAC. When an additional community benefit service is approved by MAD, the MCO shall cover that service as well.

[8.308.9.20 NMAC - N, 1-1-14]

8.308.9.21 ALTERNATIVE BENEFITS PLAN (ABP) BENEFITS FOR ABP MCO MEMBERS: The MAD category of eligibility "other adults" has an alternative benefit plan (ABP). The MCO shall cover the ABP specific services for an ABP member. Services are made available through a MCO under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member: (1) has limitations on specific benefits; (2) does not have all standard medicaid state plan benefits available; and (3) has some benefits, primarily preventive services that are available only to an ABP member. The ABP benefits and services are detailed in Sections 12 through 18 of 8.309.4 NMAC. All EPSDT services are available to an ABP member under 21 years. Services for an ABP member under the age of 21 years not subject to

the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. The MCO shall comply with all HSD MAD contractual provisions and with all MAD NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

A. provider networks found in 8.308.2 NMAC;
B. managed care eligibility found in 8.308.6 NMAC;
C. enrollment and disenrollment from managed care found in 8.308.7 NMAC;
D. managed care member education – rights and responsibilities found in 8.308.8NMAC;
E. care coordination found in 8.308.10 NMAC;
F. transition of care found in 8.308.11 NMAC;
G. managed care cost sharing found in 8.308.14 NMAC;
H. managed care grievance and appeals found in 8.308.15NMAC;
I. managed care reimbursement found in 8.308.20 NMAC;
J. quality management found in 8.308.21 NMAC; and
K. managed care fraud, waste and abuse found in 8.308.22.

[8.308.9.21 NMAC - N, 1-1-14]

8.308.9.22 MAD ALTERNATIVE BENEFITS PLAN GENERAL BENEFITS FOR ABP EXEMPT MEMBERS (ABP exempt): An ABP member who self-declares he or she has a qualifying condition is evaluated by his or her MCO for determination if he or she meets the ABP qualifying condition. An ABP exempt member may select to no longer utilize his or her ABP benefits package. Instead, the ABP exempt member will utilize his or her MCO's medicaid benefits package. See Sections 11-20 of this rule for detailed description of the MCO medicaid benefit services. The MCO shall comply with all HSD MAD contractual provisions and with all MAD NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

A. provider networks found in 8.308.2 NMAC;
B. managed care eligibility found in 8.308.6 NMAC;
C. enrollment and disenrollment from managed care found in 8.308.7 NMAC;
D. managed care member education – rights and responsibilities found in 8.308.8NMAC;
E. care coordination found in 8.308.10 NMAC;
F. transition of care found in 8.308.11 NMAC;
G. community benefits found in 8.308.12 NMAC;
H. managed care member rewards found in 8.308.13 NMAC
H managed care cost sharing found in 8.308.14 NMAC;
I. managed care grievance and appeals found in 8.308.15 NMAC;
J. managed care reimbursement found in 8.308.20 NMAC;
K. quality management found in 8.308.21 NMAC; and
L. managed care fraud, waste and abuse found in 8.308.22.

[8.308.9.22 NMAC - N, 1-1-14]

8.308.9.23 SERVICES EXCLUDED FROM THE MCO BENEFIT PACKAGE: MAD does not cover some services. The services which are not included in the MCO benefit package are detailed in the specific MAD NMAC rules cited in the Sections 12-21 of this rule. The following services that are covered in other medical assistance program (MAP), reimbursement shall be made by MAD or its contractor. However, the MCO is expected to coordinate these services, when applicable, and ensure continuity of care by overseeing PCP consultations, medical record updates and general coordination.

A. **Medicaid in the schools:** Services are covered under 8.320.6 NMAC. Reimbursement for services is made by MAD or its contractor.

B. **Special Rehabilitation Services -Family Infant Toddler (FIT):** Early intervention services provided for a member birth to three (3) years of age who has or is at risk for a developmental delay. Reimbursement for services is made by MAD or its contractor.

[8.308.9.23 NMAC - N, 1-1-14]

HISTORY OF 8.308.9 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 12 COMMUNITY BENEFIT

8.308.12.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.12.1 NMAC - N, 1-1-14]

8.308.12.2 SCOPE: This rule applies to the general public.
[8.308.12.2 NMAC - N, 1-1-14]

8.308.12.3 STATUTORY AUTHORITY: 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 Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.12.3 NMAC - N, 1-1-14]

8.308.12.4 DURATION: Permanent.
[8.308.12.4 NMAC - N, 1-1-14]

8.308.12.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.12.5 NMAC - N, 1-1-14]

8.308.12.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division (MAD) programs.
[8.308.12.6 NMAC - N, 1-1-14]

8.308.12.7 DEFINITIONS:

A. Agency based community benefit (ABCB): The community benefit (CB) services offered to a member who does not wish to self-direct his or her CB services.

B. ABCB care plan: For a member who is participating in the ABCB approach, the care plan outlines the specific community benefit services that the member and the care coordinator have identified as needed services through the comprehensive needs assessment (CNA).

C. Authorized agent: The individual that has been legally appointed by the appropriate court to act on behalf of the eligible recipient as stated in the court's order. The member's authorized agent may be a service provider (depending on the scope of the court's order) for the member.

D. Authorized representative: The member may choose to appoint an authorized representative designated to have access to medical, behavioral health and financial information for the purpose of offering support and assisting the eligible recipient in understanding his or her community benefit services. The eligible recipient may designate a person to act as an authorized representative by signing a release of information form indicating his or her consent to the release of confidential information. The authorized representative will not have the authority to direct the member's community benefit services, which remains the sole responsibility of the member or his or her authorized agent. The member's authorized representative does not need a legal relationship with the member. The authorized representative cannot serve as the member's support broker

E. Budget: The maximum budget allotment available to a self-directed community benefit (SDCB) member, determined by his or her CNA. Based on this maximum amount, the eligible member will develop a care plan in collaboration with their support broker to meet his or her assessed functional, medical and habilitative needs to enable that member to remain in the community.

F. Care coordinator: The care coordinator provides care coordination activities that comply with all state and federal requirements. This includes, but is not limited to: assigning an appropriate care coordination level; performing a CNA a minimum of annually to determine physical, behavioral and long-term care needs; developing a budget based on those needs; and delivering on-going care coordination services based on the member's assessed need and in accordance with the care plan and contractual obligations.

G. Comprehensive care plan: A comprehensive plan that includes community benefit services that meet the member's long-term, physical and behavioral health care needs which must include, but is not limited to: the amount, frequency and duration of the community benefit services, the cost of goods and services; the type of provider who will furnish each service; other services the member will access; and the member's available supports

that will complement community benefit services in meeting the individual's needs. The member works with his or her care coordinator, support broker or both to develop a care plan which is submitted to the managed care organization (MCO) for review and approval.

H. Comprehensive needs assessment (CNA): The comprehensive needs assessment will be conducted in person, in the member's primary place of residence, by the MCO care coordinator for a member who is assigned a care coordination level of two or three. The CNA will assess the physical, behavioral health, and long-term care needs; identify potential risks and provide social and cultural information. The results of the CNA will be used to create the care plan which is based on the member's assessed needs.

I. Eligible member: An individual who has been deemed medically and financially eligible, and through the self-assessment instrument has either been deemed able to self-direct or has chosen an employer of record (EOR) to perform those functions. A member must continue to meet medical and financial eligibility to continue accessing community benefits.

J. Employer of record (EOR): The employer of record is the individual responsible for directing the work of SDCB 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 member may be his or her own EOR unless the member is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. A member may also designate an individual of his or her choice to serve as the EOR, subject to the EOR meeting the qualifications specified in this rule.

K. Financial management agency (FMA): An entity that contracts with a HSD MCO to provide the fiscal administration functions for members participating in the SDCB approach.

L. Legally responsible individual (LRI): A legally responsible individual 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.

M. The level of care (LOC): A member must meet a specific LOC to be eligible for a specific community benefit service.

N. Self-directed community benefit (SDCB): The community benefit services offered to a member who is able to and who chooses to self-direct his or her CB services.

O. SDCB care plan: For a member who selected the SDCB approach, the care plan is the services that the member and the support broker have identified through the CNA that will be purchased with the member's budget.

P. Support broker: The function of the support broker is to directly assist the member in implementing the care plan and budget to ensure access to SDCB services and supports and to enhance success with self-direction. The support broker's primary function is to assist the member with employer or vendor related functions and other aspects of implementing his or her care plan and budget.

[8.308.12.7 NMAC - N, 1-1-14]

8.308.12.8 MISSION STATEMENT: 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.

[8.308.12.8 NMAC - N, 1-1-14]

8.308.12.9 MANAGED CARE COMMUNITY BENEFIT OPTIONS: A MCO member, meeting specific LOC, can select the approach to receiving his or her community benefit services. The MCO offers two approaches to the delivery of these services: agency based or self-directed. The MCO shall use the nursing facility (NF) LOC criteria for determining medical eligibility for community benefits.

[8.308.12.9 NMAC - N, 1-1-14]

8.308.12.10 AGENCY BASED COMMUNITY BENEFIT (ABCB): The MCOs shall offer the ABCB approach to its member who meets the nursing facility (NF) LOC and is determined through a CNA or reassessment to need MCO community benefit services. Although a member's assessment for the amount and types of services may vary, ABCB services are not provided 24 hours per day. A member has the option of choosing the ABCB or the SDCB approach. A member cannot participate in both community benefit approaches concurrently.

[8.308.12.10 NMAC - N, 1-1-14]

8.308.12.11 ELIGIBLE ABCB PROVIDERS: All ABCB agencies must apply and be approved to be a MAD provider and must then contract with any or all approved MCOs. A complete listing of all CB provider

qualifications and responsibilities are detailed in the MAD MCO manual.
[8.308.12.11 NMAC - N, 1-1-14]

8.308.12.12 ELIGIBLE ABCB MEMBERS: Enrollment in ABCB is contingent upon the member meeting the eligibility requirements as described in the MAD New Mexico Administrative Code (NMAC) eligibility rules, and the availability of funding as appropriated by the New Mexico legislature.
[8.308.12.12 NMAC - N, 1-1-14]

8.308.12.13 COVERED SERVICES IN AGENCY BASED COMMUNITY BENEFIT (ABCB):

A. Adult day health: adult day health services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of a member that are incorporated into the member's care plan.

(1) Adult day health services are provided by a licensed community-based adult day-care facility that offers health and social services to assist a member to achieve his or her optimal functioning.

(2) Private duty nursing services and skilled maintenance therapies (physical, occupational and speech) may be provided within the adult day health setting and in conjunction with adult day health services but would be reimbursed separately from his or her adult day health services.

B. Assisted living is a residential service that provides a homelike environment, which may be in a group setting, with individualized services designed to respond to the member's needs as identified and incorporated in the care plan.

(1) Core services are a broad range of activities of daily (ADL) living including: personal support services (homemaker, chore, attendant services, meal preparation); companion services; medication oversight (to the extent permitted under state law); 24-hour on-site response capability: (a) to meet scheduled or unpredictable member's needs, and (b) to provide supervision, safety, and security.

(2) Services include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board. Nursing and skilled therapy services are incidental, rather than integral to, the provision of assisted living services. Services provided by third parties must be coordinated with the assisted living provider.

C. Behavior support consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, his or her parents, family, and primary caregivers with coping skills which promote maintaining the member in a home environment.

(1) Behavior Support Consultation:

(a) informs and guides the member's paid and unpaid caregivers about the services and supports that relate to the member's medical and behavioral health condition;

(b) identifies support strategies for a member that 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;

(c) supports effective implementation based on a functional assessment;

(d) collaborates with medical and ancillary therapists to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and

(e) monitors and adapts support strategies based on the response of the member and his or her service and support providers.

(2) Based on the member's care plan, services are delivered in an integrated, natural setting or in a clinical setting.

D. Community transition services are non-recurring set-up expenses for a member who is transitioning from an institutional or another provider-operated living arrangement (excluding assisted living) to a living arrangement in a private residence where the member is directly responsible for his or her own living expenses.

(1) Allowable expenses are those necessary to enable the member to establish a basic household that does 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 and bath linens;

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

(d) services necessary for the member's health and safety, such as, but not limited to, pest

eradication and one-time cleaning prior to occupancy; and

(e) moving expenses.

(2) Community transition services do not include monthly rental or mortgage expense, food, regular utility charges, household appliances, or items that are intended for purely diversional or recreational purposes.

(3) Community transition services are limited to $3,500 per member every five years. In order to be eligible for this service, the member must have a NF stay of at least 90-consecutive days prior to transition to the community.

E. Emergency response services provide an electronic device that enables a member to secure help in an emergency at his or her home, avoiding institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when the "help" button is activated. The response center is staffed by trained professionals.

(1) Emergency response services include: testing and maintaining equipment; training the member, his or her caregivers and first responders on use of the equipment; 24-hour monitoring for alarms; checking systems monthly or more frequently (if warranted by electrical outages, severe weather, etc.); and reporting member emergencies and changes in the member's condition that may affect service delivery.

F. Employment supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted.

(1) The job coach provides: (a) training, skill development; (b) employer consultation that a member may require while learning to perform specific work tasks on the job; (c) co-worker training; (d) job site analysis; (e) situational and vocational assessments and profiles; (e) education of the member and co-workers on rights and responsibilities; and (f) benefits counseling. The service must be tied to a specific goal in the member's care plan.

(2) Job development is a service provided to a member by skilled staff. The service has five components:

(a) job identification and development activities;

(b) employer negotiations;

(c) job restructuring;

(d) job sampling; and

(e) job placement.

(3) Employment supports are 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 the member receiving services as a result of his or her disabilities, and does not include payment for the supervisory activities rendered as a normal part of the business setting.

(4) Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

(a) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(b) payments that are passed through to users of supported employment programs; or

(c) payments for training that is not directly related to an member's supported employment program.

(5) Federal financial participation cannot be claimed to defray expenses associated with starting up or operating a business.

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

(1) Adaptations include the installation of:

(a) ramps and grab-bars;

(b) widening of doorways and hallways;

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

(d) lifts and 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/additions;

(h) trapeze and mobility tracks for home ceilings;

(i) automatic door openers/doorbells;
(j) voice-activated, light-activated, motion-activated and electronic devices;
(k) fire safety adaptations; air filtering devices;
(l) heating and cooling adaptations;
(m) glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and
(n) alarm and alert systems, including signaling devices.

(2) All services shall be provided in accordance with applicable federal and state statutes, regulations and roles and local building codes.

(3) Non-covered adaptations or improvements to the member's home:
(a) general utility which are not for direct medical or remedial benefit to the member; and
(b) adaptations that add to the total square footage of the member's resident except when necessary to complete an approved adaptation.

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

(5) Environmental modification services to a member are limited to $5,000 every five years. Additional services may be requested if the member's health and safety needs exceed the specified limit.

H. Home health aide services provide total care or assist the member in all ADLs.

(1) Total care includes: the provision of bathing (bed, sponge, tub, or shower); shampoo (sink, tub, or bed); care of nails and skin; oral hygiene; toileting and elimination; safe transfer techniques and ambulation; normal range of motion and positioning; and adequate oral nutrition and fluid intake.

(2) The home health aide services assist the member in a manner that promotes an improved quality of life and a safe environment for him or her. Home health aide services are intermittent and provided primarily on a short-term basis; whereas, home health aide services are provided hourly, for eligible beneficiaries who need this service on a more long term basis. Home health aide services can be provided outside the member's home.

(3) Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home health aides perform an extension of therapy services:
(a) bowel and bladder care;
(b) ostomy site care;
(c) personal care;
(d) ambulation and exercise;
(e) household services essential to health care at home;
(f) assisting with medications that are normally self-administered;
(g) reporting changes in patient conditions and needs; and
(h) completing appropriate records.

(4) Home health aide services must be provided under the supervision of a registered nurse (RN) licensed by the New Mexico board of nursing, or other appropriate professional staff. Such staff must make a supervisory visit to the member's residence at least every two weeks to observe and determine whether the member's goals are being met.

I. Personal Care Services (PCS) are provided to a member unable to perform a range of ADLs and instrumental activities of daily living (IADL). PCS shall not replace natural supports such as the member's family, friends, individuals in the community, clubs, and organizations that are able and consistently available to provide support and service to the member.

(1) PCS is a benefit for a member 21 years of age or older who does not receive other MAD waiver services and who meets the eligibility for CB services. A member must have a current CNA that specifically states PCS is an appropriate CB service: A member under 21years of age can access his or her PCS through the EPSDT program.

(2) **PCS delivery models:** A member who has selected consumer-delegated as his or her delivery model may select either the consumer-delegated or the consumer-directed delivery of his or her PCS. The MCO's

care coordinator is responsible for explaining both models to each member, initially, and annually thereafter.

(a) The consumer delegated model allows the member to select his or her PCS agency to perform all PCS employer-related tasks. This agency is responsible for ensuring all PCS are delivered to the member.

(b) The consumer-directed model allows the member to oversee his or her own PCS delivery, and requires that the member to work with his or her PCS agency who then acts as a fiscal intermediary agency to processing all financial paperwork to be submitted to the MCO. The agency must be certified by MAD or its designee in order to perform PCS consumer-delegated and consumer-directed responsibilities in order to be eligible for reimbursement.

(c) A member who is unable to select or who is unable to communicate which PCS delivery model he or she selects, his or her authorized agent will then select and participate on behalf of the member. The member's authorized agent status must be properly documented with the member's PCS agency.

(i) If consumer-delegated is selected, the agency and the member's authorized agent will follow the requirements listed in (a) above; or

(ii) if consumer-directed is selected, the member's authorized agent must follow the requirements listed in (a) above.

(d) For both models, the member may select his or her family member, with the exception of the member's spouse; a friend; neighbor; or other person as his or her PCS attendant. However, his or her family member shall not be reimbursed for a service he or she would have otherwise provided. A PCS attendant, regardless of family relationship, who resides with the member shall not be paid to deliver household services, or supports such as shopping, errands, or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the member. Services include, but are not limited to, cleaning consumer's room, linens, clothing, and special diets.

(e) A member may have an authorized representative assist him or her to give instruction to the attendant or to provide information to the MCO during assessments of the member's natural services, or supports needs. An authorized representative does not have the same level of responsibility or access as an authorized agent, yet the same person may fill both responsibilities.

(i) An authorized representative must have the following qualifications: be at least 18 years of age, have a personal relationship with the member and understand the member's natural services, or supports needed, and know the member's daily schedule and routine including medications, medical and functional status, likes and dislikes, strengths and weaknesses.

(ii) An authorized representative does not make decisions for the member unless he or she is also the member's authorized agent. He or she may assist the member in communicating, as appropriate. An authorized representative may not be the member's attendant, unless he or she is also the authorized agent and has obtained written approval from the member's MCO. The authorized representative status must be properly documented with the member's PCS agency.

(3) **Eligible PCS agencies:** PCS agencies electing to provide PCS must obtain agency certification. A PCS agency provider, must comply with the requirements as listed in the MAD managed care policy manual as of the date of application for certification. PCS agencies must be an enrolled MAD provider.

(4) **Bladder and bowel care**: PCS must be related to the member's functional level to perform ADLs and IADLs as indicated in the members CNA. PCS will not include those services, or supports the member does not need or is already receiving from other sources including tasks provided by natural supports.

(a) A member who has a signed statement by his or her primary care provider (PCP) stating he or she is medically stable and able to communicate and assess his or her bladder and bowel care needs may access this service when included in his or her individual care plan.

(i) bowel care includes the evacuation and ostomy care, changing and cleaning of such bags and ostomy site skin care;

(ii) bladder care includes the attendant cueing the member to empty his or her bladder at timed intervals to prevent incontinence; and

(iii) catheter care, including the changing and cleaning of such bag.

(b) A member who is determined by his or her PCP in a signed statement to not be medically stable and not able to communicate and assess his or her bladder and bowel care needs may access these services:

(i) perineal care including cleansing of the perineal area and changing of famine sanitary products;

(ii) toileting including assisting with bedside commode or bedpan;

(iii) cleaning perineal area,

(iv) changing adult briefs or pads;
(v) cleaning changing of wet or soiled clothing; and
(vi) assisting with adjustment of clothing before and after toileting;

(5) **Meal preparation and assistance:** Meal preparation includes cutting ingredients to be cooked, cooking meals, placing and presenting the meal in front the member to eat, cutting up food into bite-sized portions for the member, or assisting the member as stated in his or her IPoC. This includes provision of snacks and fluids and may include mobility assistance and prompting or cueing the member to prepare meals.

(a) An attendant who resides in the same household as the member may not be paid for meal preparation routinely provided as part of the household division of chores, unless those services are specific to the member, such as special diets, processing of meals into edible portions, or pureeing.

(b) When two or more members are residing in the same residence, services and supports will be assessed both independently and jointly to determine the level and amount of service and support that is shared. Services and supports will be approved based on common needs and not on the member's needs. If determined by the members' MCO that he or she needs individualized service or support the MCO will include the services or supports in the members IPoC.

(6) **Eating:** Feeding or assisting the member with eating a prepared meal using a utensil or specialized utensils is a covered service. Eating assistance may include mobility assistance and prompting or cueing a member to ensure appropriate nutritional intake and monitor for choking. If the member has special needs in this area, the MCO will include specific instruction in the members IPoC on how to meet those needs. Gastrostomy feeding and tube feeding are not covered services.

(7) **Household support services:** This service is for assisting and performing interior household activities and other support services that provide additional assistance to the member. Interior household activities are limited to the upkeep of the member's personal living areas to maintain a safe and clean environment for the member, particularly a member who may not have adequate support in his or her residence. Assistance may include mobility assistance and prompting and cueing a member to ensure appropriate household support services.

(a) An attendant who resides in the same household as the member may not be paid for household support services routinely provided as part of the household division of chores, unless those services are specific to the member such as, changing the member's linens, and cleaning the member's personal living areas.

(b) When two or more members are residing in the same residence, services and supports will be assessed both independently and jointly to determine the level and amount of service and support that is shared. Services and supports will be approved based on common needs and not on the member's needs. If determined by the members' MCO that he or she needs individualized service or support the MCO will include the services or supports in the members IPoC.

(c) Services include:
(i) sweeping, mopping, or vacuuming
(ii) dusting furniture;
(iii) changing linens;
(iv) washing laundry;
(v) cleaning bathrooms includes tubs, showers, sinks, and toilets;
(vi) cleaning the kitchen and dining area including washing dishes, putting them away; cleaning counter tops, and eating areas, etc.; household services do not include cleaning up after other household members or pets;
(vii) minor cleaning of an assistive device, wheelchair and durable medical equipment (DME) is a covered service. A member must have an assistive device requiring regular cleaning that cannot be performed by the member and is not cleaned regularly by the supplier of the assistive device to be eligible to receive services under this category;
(viii) shopping or completing errands specific to the member with or without the member;
(ix) cueing a member to feed and hydrating his or her documented personal assistance animal or feed and hydrate such an animal when the member is unable;
(x) assistance with battery replacement and minor, routine wheelchair and DME maintenance is a covered service; a member must have an assistive device that requires regular maintenance, that is not already provided by the supplier of the assistive device, and that the member cannot maintain in order to be eligible to receive services under this category; and
(xi) Assisting a member self-administer: A PCP ordered prescription medication is limited to prompting and reminding the member when the PCP determines the member is able to self administer.

Assistance to a member who's PCP has determined the member is able to self administer a PCP ordered prescription medication, over-the-counter medication, administration of injections, splitting or crushing medications or filling medication boxes is not a covered service. Services include getting a glass of water or other liquid as requested by the member for the purpose of taking medications, at the direction of the member, handing the members daily medication box or medication bottle, and assist the member who can communicate to and direct the attendant on dosage amounts and oxygen tube placement.

(8) **Hygiene and grooming:** The attendant may perform for the member or the attendant may cue and prompt the member to perform the following services:

(a) bathing to include giving a sponge bath in the member's bed, bathtub or shower; transferring in and out of the bathtub or shower, turning water on and off; selecting a comfortable water temperature; bringing in water from outside or heating water for the member;

(b) dressing to include putting on, fastening, removing, clothing including shoes;

(c) grooming to include combing or brushing hair, applying make-up, trimming beard or mustache, braiding hair, shaving under arms, legs or face;

(d) oral care for a member with intact swallowing reflex to include brushing teeth, cleaning dentures or partials including the use of floss, swabs, or mouthwash;

(e) nail care to include cleaning, filing to trim, or cuticle care for member's without a medical condition. For a documented medically at-risk member; nail care is not a covered under PCS; it is a skilled nurse service. Medically at risk conditions include, but are not limited to covenous insufficiency, diabetes, peripheral neuropathy;

(f) applying lotion or moisturizer to intact skin for routine skin care;

(g) physician ordered skin care: limited to the application of skin cream when a member has a documented chronic skin condition and is determined by his or her PCP unable to self administer the medication. The member's PCP must order a prescription or over-the-counter medication to treat the condition.

(i) When the PCP determines the member is able to self administer the prescribed or over-the-counter medication the attendant is limited to prompting and reminding the member.

(ii) PCS does not include the care of a member's wounds, open sores, debridement or dressing of open wounds.

(h) prompting or cueing to ensure appropriate bathing, dressing, grooming, oral care, nail care and application of lotion for routine skin care; and

(i) mobility assistance to ensure appropriate bathing, dressing, grooming, oral care and skin care

(9) **Supportive mobility assistance:** Physical or verbal prompting and cueing mobility assistance provided by the attendant that are not already included as part of other PCS includes assistance with:

(a) ambulation to include moving around inside or outside the member's residence or living area with or without an assistive device such as a walker, cane or wheelchair;

(b) transferring to include moving to and from one location or position to another with or without an assistive devices such as in and out of a vehicle;

(c) toileting to include transferring on or off a toilet; and

(d) repositioning to include turning or changing a bed-bound member's position to prevent skin breakdown.

(10) **Non-covered services:** The following services are not covered for a member receiving PCS:

(a) services to an inpatient or resident of a hospital, NF, ICF-IID, mental health facility, correctional facility, or other institutional settings, with the exception when a member is transitioning from a NF;

(b) services that are already provided by other sources, including natural supports;

(c) household services, support services such as shopping, errands, or meal preparation that are routinely provided as part of the household division of chores;

(d) services provided by a person not meeting the requirements and qualifications of a personal care attendant; including but not limited to, training and criminal background checks;

(e) services not approved in the member's IPoC;

(f) childcare, pet care, or personal care for other household members. This does not include the member's documented assistant service animal;

(g) retroactive services;

(h) services provided to a individual who is not a MCO member or does not meet the eligibility criteria for CB services;

(i) member assistance with finances and budgeting;

(j) member appointment scheduling;
(k) member range of motion exercises;
(l) wound care of open sores and debridement or dressing of open wounds;
(m) filling of medication boxes, cutting or grinding pills, administration of injections, assistance with over-the-counter medication or medication that the member cannot self-administer;
(n) skilled nail care for a member documented as medically at-risk;
(o) medically necessary transportation when available through the member's MCO general benefit services;
(p) bowel and bladder services that include insertion or extraction of a catheter or digital stimulation; and
(q) gastrostomy feeding and tube feeding.

J. Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for a member who is 21 years of age and older with intermittent or extended direct nursing care in his or her home.

(1) Services include:
(a) medication management,
(b) administration and teaching;
(c) aspiration precautions;
(d) feeding tube management;
(e) gastrostomy and jejunostomy;
(f) skin care;
(g) weight management;
(h) urinary catheter management;
(i) bowel and bladder care;
(j) wound care;
(k) health education;
(l) health screening;
(m) infection control;
(n) environmental management for safety;
(o) nutrition management;
(p) oxygen management;
(q) seizure management and precautions;
(r) anxiety reduction;
(s) staff supervision; and
(t) behavior and self-care assistance.

(2) All services provided under a written physician's order and must be rendered by New Mexico board of nursing licensed RN or a licensed practical nurse (LPN) who provides services within his or her scope of practice.

K. Respite services are provided to a member unable to care for him or herself and are furnished on a short-term basis to allow the member's unpaid primary caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency.

(1) Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or NF, that meet the qualifications for MAD provider enrollment requirements. For purposes of ABCB eligibility, when respite services are delivered through an institutional provider, the member is not considered a resident of the institution.

(2) Respite care services include:
(a) medical and non-medical health care;
(b) personal care; bathing;
(c) showering; skin care;
(d) grooming;
(e) oral hygiene;
(f) bowel and bladder care;
(g) catheter and supra-pubic catheter care;
(h) preparing or assisting in preparation of meals and eating;
(i) administering enteral feedings;
(j) providing home management skills;

(k) changing linens;
(l) making beds;
(m) washing dishes;
(n) shopping; errands;
(o) calls for maintenance;
(p) assisting with enhancing self-help skills, such as promoting use of appropriate interpersonal communication skills and language, working independently without constant supervision or observation;
(q) providing body positioning, ambulation and transfer skills;
(r) arranging for transportation to medical or therapy services;
(s) assisting in arranging health care needs and follow-up as directed by primary care giver, physician, and care coordinator; and
(t) ensuring the health and safety of the member at all times.

(3) Respite may be provided on either a planned or an unplanned basis and may be provided in a variety of settings. If unplanned respite is needed, the appropriate agency personnel will assess the situation, and with the caregiver, recommend the appropriate setting for respite services to the member. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing care to the member.

(4) Respite services are limited to a maximum of 100 hours annually per care plan year provided there is an unpaid primary caretaker. Additional hours may be requested if a member's health and safety needs exceed the specified limit.

L. Skilled maintenance therapy services for a member 21 years and older are provided when his or her MCO's general skilled therapy services are exhausted or not a covered MCO's benefit. The community benefit skilled maintenance therapy services include physical therapy, occupational therapy or speech language therapy. Therapy services focus on improving functional independence, health maintenance, community integration, socialization, and exercise, and enhance the support and normalization of the member's family relationships.

(1) Physical therapy services promote gross and fine motor skills, facilitate independent functioning and prevent progressive disabilities. Specific services may include:
(a) professional assessment, evaluation and monitoring for therapeutic purposes;
(b) physical therapy treatments and interventions;
(c) training regarding PT activities;
(d) use of equipment and technologies or any other aspect of the member's physical therapy services;
(e) designing, modifying or monitoring use of related environmental modifications;
(f) designing, modifying, and monitoring use of related activities supportive to the care plan goals and objectives; and
(g) consulting or collaborating with other service providers or family enrollees, as directed by the member.

(2) Occupational therapy (OT) services promote fine motor skills, coordination, sensory integration, and facilitate the use of adaptive equipment or other assistive technology. Specific services may include:
(a) teaching of daily living skills;
(b) development of perceptual motor skills and sensory integrative functioning;
(c) design, fabrication, or modification of assistive technology or adaptive devices;
(d) provision of assistive technology services;
(e) design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;
(f) use of specifically designed crafts and exercise to enhance function; training regarding OT activities; and
(g) consulting or collaborating with other service providers or family enrollees, as directed by the member.

(3) Speech and language therapy (SLT) services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology; and prevent progressive disabilities. Specific services may include:
(a) identification of communicative or oropharyngeal disorders and delays in the development of communication skills;
(b) prevention of communicative or oropharyngeal disorders and delays in the development of communication skills;

(c) development of eating or swallowing plans and monitoring their effectiveness;
(d) use of specifically designed equipment, tools, and exercises to enhance function;
(e) design, fabrication, or modification of assistive technology or adaptive devices;
(f) provision of assistive technology services;
(g) adaptation of the member's environment to meet his or her needs;
(h) training regarding SLT activities; and
(i) consulting or collaborating with other service providers or family enrollees as directed by the member.

(4) A signed therapy referral for treatment must be obtained from the member's PCP. The referral will include frequency, estimated duration of therapy and treatment, and procedures to be provided.
[8.308.12.13 NMAC - N, 1-1-14]

8.308.12.14 ABCB NON-COVERED SERVICES: MAD and the member's MCO do not cover certain procedures, services, or miscellaneous items. The member uses his or her MCO general benefits for non-ABCB services, and these services are not included in the ABCB care plan. See specific MAD NMAC rules, sections of this rule, and the MAD MCO manual for additional information on service coverage and limitations.
[8.308.12.14 NMAC - N, 1-1-14]

8.308.12.15 SELF-DIRECTED COMMUNITY BENEFIT (SDCB): The MCO shall offer the SDCB approach to a member who meets a NF LOC and is determined through a comprehensive needs assessment or reassessment to need the community benefit (CB). Self-direction affords a member the opportunity to have choice and control over how his or her CB services are provided and who provides the services. Although a member's assessment for the amount and types of services may vary, SDCB services are not provided 24 hours per day. Services are reimbursed according to the MAD rate schedule that has a range of allowable reimbursement to a provider of a specific service. The member's MCO approves the final reimbursement rate for each provider of a CB service. A member has the option of choosing the ABCB or the SDCB approach. A member cannot participate in both community benefit approaches concurrently.

[8.308.12.15 NMAC - N, 1-1-14]

8.308.12.16 ELIGIBLE PROVIDERS: The FMA, member or his or her EOR shall verify that a potential provider meets all applicable qualifications prior to rendering a service. If a provider or employee is unable to pass a nationwide criminal history screening pursuant to NMSA 1978, 29-12-2 et seq. or is listed in the abuse registry as defined in NMSA 1978, 27-7a-1 et seq., that person may not be employed to render any service to the MCO's member. Following formal approval from the MCO, LRI (including parents of minors), who must provide care to the minor, may serve as a provider under extraordinary circumstances in order to assure the health and welfare of the member and to avoid his or her institutionalization. The MCO shall make decisions regarding legally responsible LRI serving as providers for members on a case by case basis. Following formal approval from the MCO, a spouse of a member may serve as a provider under extraordinary circumstances in order to assure the health and welfare of the member and to avoid institutionalization. The MCO shall provide such approval on a case by case basis.

A. An EOR shall have an employment or vendor agreement with each of the member's providers. The employee or vendor agreement template shall be prescribed by MAD. Prior to a payment being made to a provider for SDCB services, the FMA shall ensure that: the provider meets all qualifications; and an employee agreement or vendor agreement is signed between the EOR and the provider. A member's employment agreement shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Employment agreements shall be signed by the new EOR when there is a change in EORs. A copy of each employee agreement or vendor agreement shall be provided to the member and EOR. Refer to the MAD MCO manual for a complete listing of all SDCB provider qualifications and responsibilities.
[8.308.12.19 NMAC - N, 1-1-14]

8.308.12.17 ELIGIBLE MEMBERS: Enrollment in the SDCB is contingent upon the MCO member meeting the eligibility requirements as described in the MAD NMAC managed care eligibility rules, and upon the availability of funding as appropriated by the New Mexico legislature.
[8.308.12.20 NMAC - N, 1-1-14]

8.308.12.18 COVERED SERVICES IN SELF-DIRECTED COMMUNITY BENEFIT SDCB: MAD and

the member's MCO cover certain procedures, services, and miscellaneous items. For those services that are the same in ABCB and SDCB, detailed descriptions are found in 8.308.12.13 NMAC, and the corresponding sections are referenced accordingly.

A. Behavior support consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, his or her parents, family, and primary caregivers with coping skills which promote maintaining the member in a home environment. See Section 13 Subsection C of this rule for detail description of this service.

B. Customized community supports include participation in community congregate day programs and centers that offer functional meaningful activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills. Customized community supports may include 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 4 or more hours per day one or more days per week as specified in the member's care plan.

C. Emergency response services provide an electronic device that enables a member to secure help in an emergency at his or her home, avoiding institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when the "help" button is activated. The response center is staffed by trained professionals. See Section 13 Subsection E of this rule for detail description of this service.

D. Employment supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. See Section 13 Subsection F of this rule for detail description of this service.

E. Environmental modification services include: the purchase of, the installation of equipment for the physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance the member's level of independence. See Section 13 Subsection G of this rule for detailed description of this service.

F. Home health aide services provide total care or assist the member in all ADL. See Section 13 Subsection H of this rule for a detailed description of this service.

G. Homemaker services are provided on an episodic or continuing basis to assist the member with ADL, performance of general household tasks, provide companionship to acquire, maintain, or improve social interaction skills in the community, and enable the member to accomplish tasks he or she would normally do for him or herself if he or she did not have a disability.

(1) Homemaker services are provided in the member's home and in the community, depending on the member's needs. The member identifies the homemaker worker's training needs, and, if the member is unable to do the training him or herself, the member arranges for the needed training.

(2) Services are not intended to replace supports available from a primary caregiver. Homemaker services are not duplicative of home health aide services.

(3) 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.

(4) When two or more members are residing in the same residence, services and supports will be assessed both independently and jointly to determine the level and amount of service and support that is shared. Services and supports will be approved based on common needs and not on the member's needs. If determined by the members' MCO that he or she needs individualized service or support the MCO will include the services or supports in the members care plan.

H. Non-medical transportation services are offered to enable a member to gain access to services, activities, and resources, as specified by his or her care plan. Non-medical transportation services in the SDCB are offered in accordance with the member's care plan. Payment for SDCB non-medical transportation services is made to the member's individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the member.

I. Nutritional counseling services include assessment of the member's nutritional needs, development and revision of the member's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.

J. Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for a member who is 21 years of age and older with intermittent or extended direct nursing care in his or her home. See Section 13 Subsection J of this rule for a detailed description of this service.

K. Related goods are equipment, supplies or fees and memberships, not otherwise provided through

the member's MCO general benefits.

(1) Related goods must address a need identified in the member's care plan including improving and maintaining the member's opportunities for full membership in the community, and meets the following requirements:

(a) be responsive to the member's qualifying condition or disability;
(b) accommodates the member in managing his or her household;
(c) facilitate the member's ADL;
(d) promotes the member's personal safety and health;
(e) affords the member an accommodation for greater independence;
(f) advances the desired outcomes in the member's care plan; and
(g) decreases the need for other medicaid services.

(2) Related goods will be carefully monitored by the member's MCO to avoid abuses or inappropriate use of this benefit.

L. Respite services are provided to a member unable to care for him or herself and are furnished on a short-term basis to allow the member's unpaid primary caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. See Section 13 Subsection K of this rule for a detailed description of this service.

M. Skilled maintenance therapy services for a member 21 years and older are provided when his or her MCO's general skilled therapy services are exhausted or not a covered MCO's benefit. The community benefit skilled maintenance therapy services include physical therapy, occupational therapy or speech language therapy. Therapy services focus on improving functional independence, health maintenance, community integration, socialization, and exercise, and enhance the support and normalization of the member's family relationships. See Section 13 Subsection L of this rule for a detailed description of this service.

N. Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his or her care plan when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services.

(1) 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 to a member. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits to the member.

(2) Biofeedback uses visual, auditory or other monitors to feed back physiological information of which the member is normally unaware. This technique enables a member to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order for the member to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating the member's pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

(3) Chiropractic care for a member 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, the 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 of the member.

(4) Cognitive rehabilitation therapy services for a member 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 ADL. The overall goal is to restore the member's function in a cognitive domain or set of domains, or to teach compensatory strategies to overcome specific cognitive problems.

(5) 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 a member with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the member use cognitive functioning, especially for sequencing and memory. A member with attention deficits and behavior problems is redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production of the member.

(6) Massage therapy for a member 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, a member's ability to be more independent in the performance of ADL; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

(7) Naprapathy focuses, for a member, 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 for a member.

(8) A native American healer is an individual who is recognized as a healer within his or her respective native American community. A native American member may be from one of the 22 sovereign tribes, nations and pueblos in New Mexico or may be from other tribal backgrounds. A native American healer delivers a wide variety of culturally-appropriate therapies that support the member by addressing the member's physical, emotional and spiritual health. Treatments delivered by a native American healer may include prayer, dance, ceremony and song, plant medicines and foods; participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel or other sacred objects. A native American healer provides opportunities for the member to remain connected with his or her tribal community. The communal and spiritual support provided by this type of healing can reduce pain and stress and improve quality of life. It is also important to note that some tribes, nations and pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious ties.

[8.308.12.16 NMAC - N, 1-1-14]

8.308.12.19 SDCB NON-COVERED SERVICES: MAD and the member's MCO do not cover certain procedures, services, or miscellaneous items. The member uses his or her MCO general benefits for non-SBCB services, and these services are not included in the SBCB care plan. See specific MAD NMAC rules, sections of this rule, and the MAD MCO manual for additional information on service coverage and limitations.

[8.308.12.17 NMAC - N, 1-1-14]

8.308.12.20 TRANSITION TO THE SELF-DIRECTED COMMUNITY BENEFIT: A member who meets a NF LOC and who qualifies for MCO CB must first access services through his or her MCO's ABCB approach. After 120 calendar days, the member may continue his or her CB services provided through the MCO's ABCB or may now select the MCO's SDCB approach. The member's MCO shall obtain a signed statement from the member regarding his or her decision to participate in the SDCB approach. The signed statement will include member attestation that he or she understands the responsibilities of self directing his or her CB services, including the management of his or her care plan. For a member transitioning from a NF:

(1) and the member continues to meet NF LOC;

(2) the member selects his or her MCO's SDCB approach;

(3) the member must access CB services through the MCO's ABCB approach for the first 120 calendar days of eligibility; and

(4) after 120 calendar days, the member may transition to the MCO's SDCB.

A. Self-assessment: The member's care coordinator shall provide him or her with the MAD self-assessment instrument. The self-assessment instrument shall be completed by the member with assistance from the member's care coordinator upon request. The care coordinator shall file the completed self-assessment in the member's file.

B. Employer of record (EOR): A member who is an unemancipated minor or is under guardianship cannot serve as his or her EOR. When the member's care coordinator, based on the results of the self-assessment, determines the member requires assistance to direct his or her CB services, the member must designate an EOR to assume the functions on behalf of the member. A member that serves as his or her EOR has the option to do so or may, on his or her own, designate a person to serve as his or her EOR. A designated EOR may not also be an employee of the member. The member's file must have documentation of either the member acting as his or her EOR or of the designated EOR. The member's MCO will make the final determination on whether the member may be his or her own EOR.

C. Supports for self-direction: A member or his or her authorized agent may designate a person to provide support to the member's self-directed functions. The member or his or her authorized agent may act as his or her EOR. A member's authorized agent may function as the member's authorized representative. The member's care coordinator shall include a copy of any EOR or authorized representative forms in the member's file and provide copies to the member, the member's authorized agent, authorized representative and the FMA.

(1) Care coordination for self-direction: The MCO shall ensure that the member or the member's authorized agent fully participate in developing and administering SDCB services and that sufficient supports, such as care coordinators and support brokers, are made available to assist the member or the member's authorized agent who request or require assistance. In this capacity, the care coordinator shall fulfill, in addition to contractual requirement, the following tasks:

(a) understand member and EOR roles and responsibilities;

(b) identify resources outside the member's MCO SDCB, including natural and informal supports, that may assist in meeting the member's long term care needs;

(c) understand the array of the SDCB services;

(d) assign the annual budget for the SDCB based on the CNA to address the needs of the member;

(e) monitor utilization of SDCB services on a regular basis;

(f) conduct employer-related activities such as assisting a member in identifying a designated EOR as appropriate;

(g) identify and resolve issues related to the implementation of the member's SDCB care plan;

(h) assist the member with quality assurance activities to ensure implementation of the member's SDCB care plan and utilization of his or her authorized budget;

(i) recognize and report critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards;

(j) monitor quality of services provided by the member's support broker; and

(k) work with the member to provide the necessary assistance for successful SDCB program implementation.

(2) A support broker is a qualified vendor for a SDCB member who is either employed by or contracted by the member's MCO. At a minimum, the support broker shall perform the following functions:

(a) educate the member on how to use self-directed supports and services and provide information on program changes or updates;

(b) review, monitor and document progress of the member's SDCB care plan;

(c) assist in managing budget expenditures, complete and submit SDCB care plan and budget revisions;

(d) assist with employer functions such as recruiting, hiring and supervising SDCB providers;

(e) assist with approving and processing job descriptions for SDCB direct supports;

(f) assist with completing forms related to the member's employees;

(g) assist with approving timesheets , purchase orders or invoices for goods, obtain quotes for services and goods, as well as identify and negotiate with vendors;

(h) assist with problem solving of an employee or vendor payment issue with the FMA and other appropriate parties;

(i) facilitate resolution of any disputes regarding payment to a provider for services rendered;

(j) develop the care plan for SDCB, based on the budget amount; and

(k) assist in completing all documentation required by the FMA.

(3) FMA acts as the intermediary between the member and the member's MCO payment system and assists the member or the member's EOR with employer-related responsibilities. The FMA pays employees and vendors based upon an approved SDCB care plan and budget. The FMA assures member and program compliance with state and federal employment requirements, monitors, and makes available to the member and MAD reports

related to utilization of services and budget expenditures. Based on the member's approved individual care plan and budget, the FMA must:

(a) verify that the member is eligible for SDCB services prior to making payment for services;

(b) receive and verify that all required employee and vendor documentation and qualifications are in compliance with the MAD NMAC SBCB rules and the MAD MCO manual;

(c) establish an accounting for each member's budget;

(d) process and pay invoices for goods, services, and supports approved in the member's SDCB care plan and supported by required documentation; and

(e) process all payroll functions on behalf of the member and EOR including:

(i) collects and processes timesheets of employees in accordance with the MAD approved payment schedule;

(ii) processes payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance;

(iii) tracks and reports disbursements and balances of the member's budget and provides a monthly report of expenditures and budget status to the member and his or her support broker, and quarterly and annual documentation of expenditures to MAD;

(iv) receives and verifies a provider's agreement, including collecting required provider qualifications;

(v) monitors hours billed for services provided and the total amounts billed for all goods and services during the month;

(vi) answers inquiries from the SDCB member and solves problems related to the FMA's responsibilities; and

(vii) reports any concerns related to the health and safety of the member or when the member is not following his or her approved SDCB care plan to the MCO and MAD as appropriate.

D. Budget: The member's MCO will determine the maximum annual budget allotment based on the member's CNA. The member may request a revision to the SDCB care plan and budget when a change in circumstances warrants such revisions, such as a change in health condition or loss of natural supports. All changes are subject to assessment and approval by the MCO.

E. SDCB care plan: The support broker and the member shall work together to develop an annual SDCB care plan for the SDCB services the member is identified to need as a result of his or her CNA. The SDCB care plan will not exceed the MCO determined budget. The support broker and member shall refer to the rates specified by HSD in selecting payment rates for qualified providers and vendors. The care plan for SDCB services shall be based upon the member's assessed needs and approved by the member's MCO. The support broker shall closely monitor the utilization of SDCB care plan services to ensure that the member does not exceed the approved annual budget.

(1) SDCB care plan review criteria: Services and goods identified in the member's requested SDCB care plan may be considered for approval by the MCO if all of the following requirements are met:

(a) the services or goods must be responsive to the member's qualifying condition or disability;

(b) the services or goods must address the member's clinical, functional, medical or habilitative needs;

(c) the services or goods must facilitate ADL per the CNA;

(d) the services or goods must promote the member's personal health and safety;

(e) the services or goods must afford the member an accommodation for greater independence;

(f) the services or goods must support the member to remain in the community and reduce his or her risk for institutionalization;

(g) the need for the services or goods must be approved and documented in the CNA and advance the desired outcomes in the member's care plan;

(h) the services or goods are not available through another source;

(i) the service or good is not prohibited by federal regulations, state rules and instructions;

(j) the proposed rate for each service is the MAD approved rate for that chosen service;

(k) the proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and

(l) the estimated cost of the service or good is specifically documented in the member's budget.

(2) SDCB care plan revisions: The SDCB care plan may be modified based upon a change in the member's needs or circumstances, such as a change in the member's health status or condition or a change in the eligible member's support system, such as the death or disabling condition of a family or other individual who was

providing services. The member is responsible for assuring that all expenditures are in compliance with the most current determination of need. SDCB care plan revisions involve requests to add new goods or services to a care plan or to reallocate funds from any line item to another approved line item. SDCB care plan revisions must be submitted to the member's MCO for review and determination. Other than for critical health and safety reasons, SDCB care plan revisions may not be submitted to the MCO for review within the last 60 calendar days of the care plan year. Prior to submitting a SDCB care plan revision request, the member is responsible for communicating any utilization of services that are not in compliance with the care plan to the support broker. At the MCO's discretion, a revision to the SDCB care plan may require another CNA. If the SDCB care plan revision includes a request for additional services, another CNA must be performed by the MCO to determine whether the change in circumstance or need warrants additional funding for additional services prior to approval.

F. SDCB back-up plan: The support broker shall assist the member and his or her EOR in developing a back-up plan for the SDCB that adequately indentifies how the member and EOR will address situations when a scheduled provider is not available or fails to show up as scheduled. The member's support broker shall assess the adequacy of the member's back-up plan at least on an annual basis and when changes in the type, amount, duration, scope of the SDCB or the schedule of needed services, or a change of providers (when such providers also serve as back-up to other providers) or change in availability of paid or unpaid back-up providers to deliver needed care.

G. Member and EOR training: The member's MCOs shall require the member electing to enroll in the SDCB approach and his or her EORs to receive relevant training. The support broker shall be responsible for arranging for initial and ongoing training of the member and his or her EORs.

(1) At a minimum, self-direction training for member and his or her EOR shall address the following issues:

(a) understanding the role of the member and EOR with SDCB;
(b) understanding the role of the care coordinator, support broker, the MCO, and the FMA;
(c) selecting providers and vendors;
(d) critical incident reporting;
(e) member abuse and neglect prevention and reporting;
(f) being an employer, evaluating provider performance and managing providers;
(g) fraud and abuse prevention and reporting;
(h) performing administrative tasks, such as, reviewing and approving electronically captured visit information and timesheets and invoices; and
(i) scheduling providers and back-up planning.

(2) The member's MCO shall arrange for ongoing training for the member and his or her EOR upon request or if a support broker, through monitoring, determines that additional training is warranted.

H. Claims submission and payment: The member or EOR shall review and approve timesheets of his or her providers and invoices from his or her vendors to determine accuracy and appropriateness. No SDCB provider shall exceed 40 hours paid work in a consecutive seven calendar day period per EOR. Timesheets must be submitted and processed on a two-week pay schedule according to the FMA's prescribed payroll payment schedule. The FMA shall be responsible for processing the member's payments for approved services and goods.
[8.308.12.18 NMAC - N, 1-1-14]

8.308.12.21 TERMINATION FROM SDCB: The MCO may involuntarily terminate a member from the self-directed community benefit under any of the following circumstances:

A. The member or his or her EOR refuses to follow MAD NMAC rules and his or her MCO policies after receiving focused technical assistance on multiple occasions and support from his or her care coordinator or FMA, which is supported by documentation of the efforts to assist the member. For purposes of this rule, focused technical assistance is defined as a minimum of three separate occasions where the member or his or her EOR have received training, education or technical assistance, or a combination of both, from the MCO, the FMA or MAD.

B. There is an immediate risk to the member's health or safety by continued self-direction of services, i.e., the member is in imminent risk of death or serious bodily injury. Examples include but are not limited to the following:

(1) the member refuses to include and maintain services in his or her care plan that would address health and safety issues identified in his or her comprehensive needs assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, the care coordinator or the FMA;

(2) the member is experiencing significant health or safety needs and, refuses to incorporate the care coordinator's recommendations into his or her care plan, or exhibits behaviors that endanger him or her or others;

(3) the member misuses his or her SDCB budget following repeated and focused technical assistance and support from the care coordinator and the FMA, which is supported by documentation;

(4) the member expends his or her entire SDCB budget prior to the end of the care plan year; or

(5) the member or authorized agent intentionally misuses his or her SDCB services or goods.

C. The MCOs shall submit to MAD any requests to terminate a member from the SDCB approach with sufficient documentation regarding the rationale for termination. Upon MAD approval, the MCO shall notify the member regarding termination in accordance with MAD NMAC rules and MCO policies. The member shall have the right to appeal the determination by requesting an and internal MCO appeal and, if the termination is still upheld by the MCO, an HSD administrative hearing. The MCO shall facilitate a seamless transition from the SDCB to ABCB approach to ensure there are no interruptions or gaps in services. Involuntary termination of a member from SDCB shall not affect a member's eligibility for covered services or continued MCO membership.

D. A member who has voluntarily switched to ABCB or who has been involuntarily terminated from SDCB may request to be reinstated in the SDCB to his or her MCO. Such requests may not be made more than once in a calendar year. The member's SDCB reinstatement for members involuntarily terminated is at the discretion of his or her MCO. The care coordinator shall work with the member's FMA to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to such reinstatement. All members shall be required to participate in SDCB training programs prior to his or her SDCB reinstatement.
[8.308.12.21 NMAC - N, 1-1-14]

HISTORY OF 8.308.12 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 13 MEMBER REWARDS

8.308.13.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.13.1 NMAC - N, 1-1-14]

8.308.13.2 SCOPE: This rule applies to the general public.
[8.308.13.2 NMAC - N, 1-1-14]

8.308.13.3 STATUTORY AUTHORITY: 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 Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.13.3 NMAC - N, 1-1-14]

8.308.13.4 DURATION: Permanent.
[8.308.13.4 NMAC - N, 1-1-14]

8.308.13.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.13.5 NMAC - N, 1-1-14]

8.308.13.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.308.13.6 NMAC - N, 1-1-14]

8.308.13.7 DEFINITIONS: [RESERVED]
[8.308.13.7 NMAC - N, 1-1-14]

8.308.13.8 MISSION STATEMENT: 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.
[8.308.13.8 NMAC - N, 1-1-14]

8.308.13.9 ELIGIBLE MEMBERS: A member of a HSD contracted managed care organization (MCO) is eligible to participate in his or her MCO's member rewards program.

A. For a native American member who elects to opt out of receiving MAD services through a HSD contracted MCO, and retains medical assistance programs (MAP) eligibility, he or she no longer will earn reward credits as of the last day of enrollment in his or her MCO.

B. Upon losing eligibility for continued enrollment in a HSD contracted MCO, the individual no longer will earn member reward credits.
[8.308.13.9 NMAC - N, 1-1-14]

8.308.13.10 REWARD CREDITS: A member may earn reward credits when engaging in a MCO selected healthy behavioral. Each healthy behavioral receives a one-time reward per calendar year. Reward credits are determined for specific member healthy behaviors. Details on the requirements to earn a healthy behavior reward credit are made available to a member on the medical assistance division's (MAD) website and provided in writing to a member through his or her MCO.

A. **Maximum amount of a member's reward credit balance:** A member is limited to a maximum reward credit balance of $125.00 at any one time. Each time a member's balance is less than the maximum amount, the member is eligible to earn additional reward credits up to the maximum limit.

B. **Portability of reward credits:** A member may carry his or her reward credits when transitioning from one HSD contracted MCO to another HSD contracted MCO. When a member earns reward credits for a specific healthy behavior, he or she may not earn reward credits for the same healthy behavior within the same calendar year with his or her new MCO.

C. **Retention of reward credits:** A member's reward credit balance will be accessible for the member's use up to 365 days after he or she loses MAP eligibility. For a native American who was a member of a

HSD contracted MCO, and later opts in to fee-for-service (FFS) administration of benefits, the previously earned MCO reward credits are accessible up to 365 days after the close of his or her HSD contracted MCO membership.

D. **Reward credit disputes:** If a member believes there is a discrepancy in the way his or her HSD contracted MCO has determined a reward credit or balance, the member shall contact his or her MCO for resolution.
[8.308.13.10 NMAC - N, 1-1-14]

HISTORY OF 8.308.13 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 14 COST SHARING

8.308.14.1 ISSUING AGENCY: New Mexico Human Services Department (HSD)
[8.308.14.1 NMAC - N, 1-1-14]

8.308.14.2 SCOPE: This rule applies to the general public.
[8.308.14.2 NMAC - N, 1-1-14]

8.308.14.3 STATUTORY AUTHORITY: 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 Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.14.3 NMAC - N, 1-1-14]

8.308.14.4 DURATION: Permanent.
[8.308.14.4 NMAC - N, 1-1-14]

8.308.14.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.14.5 NMAC - N, 1-1-14]

8.308.14.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.14.6 NMAC - N, 1-1-14]

8.308.14.7 DEFINITIONS:
A. **Co-payment:** A fixed dollar amount that must be paid at the time a MAD service is provided or a prescription is filled.
B. **Unnecessary utilization of services:**
(1) The unnecessary utilization of a brand name drug means using a brand name drug is not on the first tier of a preferred drug list (PDL) instead of a alternative lesser expensive drug item that is on the first tier of a PDL, unless in the prescriber's estimation, the alternative drug item available on the PDL would be less effective for treating the member's condition, or would likely have more side effects or a higher potential for adverse reactions for the member.
(2) The unnecessary utilization of an emergency department (ED) is when a member presents to an emergency room for service when the condition of the member is determined to be non-emergent after considering the medical presentation of the member, age, and other factors, but also alternative providers that may be available in the community at the specific time of day.
[8.308.14.7 NMAC - N, 1-1-14]

8.308.14.8 MISSION STATEMENT: 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.
[8.308.14.8 NMAC - N, 1-1-14]

8.308.14.9 COST SHARING IN MEDICAID MANAGED CARE PROGRAM: The medical assistance division (MAD) imposes cost-sharing (out-of- pocket) provisions on certain members and on certain services. Cost-sharing includes co-payments, coinsurance, deductibles, and other similar charges. The member's HSD contracted managed care organization (MCO) is required to impose the following co-payments as directed by MAD and in accordance with federal regulations.
A. **General requirements regarding cost sharing:**
(1) The MCO or its contracted providers may not deny services for a member's failure to pay the co-payment amounts.
(2) The MCO must take measures to educate and train both its contracted providers and members on cost-sharing requirements, and must include, at a minimum:
(a) educating and working with the MCO's hospital providers on the requirements related to

non-emergency utilization of the emergency department (ED); and

(b) for co-payments required in the case of a non-emergency utilization of an ED (an unnecessary use of services) the hospital is required, before imposing cost sharing, to provide the member with a name of and location of an available and accessible provider that can provide the service with lesser or no cost sharing and provide a referral to coordinate scheduling. If geographical or other circumstances prevent the hospital from meeting this requirement, the cost sharing may not be imposed.

(3) The MCO shall not impose cost-sharing provisions on certain services that, in accordance with federal regulations, are always exempt from cost-sharing provisions. See CFR 447.56, *Limitations on Premiums and Cost Sharing,* 8.200.430 NMAC and 8.302.2 NMAC.

(4) The MCO shall not impose cost-sharing provisions on certain member populations that, in accordance with federal and state regulations and rules, are exempt from cost-sharing provisions. The MCO and its contracted providers are required to impose co-payments on its members in the case of unnecessary utilization of a service unless the eligible recipient is exempt from the copayments; see Section 10 Subsection B of this rule.

(5) Payments to MCO contracted providers: In accordance with 42 CFR 447.56, *Limitations on Premiums and Cost Sharing* and New Mexico state statute 27-2-12.16:

(a) the MCO must reduce the payment it makes to a non-hospital contracted provider by the amount of the member's applicable cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing; and

(b) the MCO must not reduce the payment it makes to a contracted hospital provider by the amount of the member's cost sharing obligation if the contracted hospital provider is not able to collect the cost sharing obligation from the member.

(6) At the direction of MAD, the MCO must report all cost-sharing amounts collected.

(7) The MCO may not impose more than one type of cost sharing for any service, in accordance with 42 CFR 447.52.

(8) The MCO must track, by month, all co-payments collected from each individual member in the household family to ensure that the family does not exceed the aggregate limit (cap). The cap is five percent of countable family income for all individual members in a household family calculated as applicable for a month. The MCO must be able to provide each member, at his or her request, with information regarding co-payments that have been applied to claims for the member.

(9) The MCO must report to the provider when a copayment has been applied to the provider's claim and when a copayment was not applied to the provider's claim. The MCO shall be responsible for assuring the provider is aware that:

(a) the provider shall be responsible for refunding to the member any copayments the provider collects after the eligible recipient has reached the co-payment cap (five percent of the eligible recipient's family's income, calculated on a monthly basis) which occurs because the MCO was not able to inform the provider of the exemption from copayment due to the timing of claims processing;

(b) the provider shall be responsible for refunding to the member any copayments the provider collects for which the MCO did not deduct the payment from the provider's payment whether the discrepancy occurs because of provider error or MCO error; and

(c) failure to refund a collected copayment to a member and to accept full payment from the MCO may result in a credible allegation of fraud, see 8.351.2 NMAC.

B. **Unnecessary utilization of services co-payments:** The use of a brand name prescription drug in place of a generic therapeutic equivalent on the PDL and the utilization of the emergency room for non-ED services are both considered to be unnecessary utilization of services. Some members are exempt from copayments for unnecessary utilization of services.

(1) When a member obtains a brand name prescription drug in place of a generic therapeutic equivalent on his or her member's PDL, the MCO and dispensing pharmacy must impose a co-payment in the amount specified by MAD for the member, unless the member is exempt from copayments for unnecessary utilization of services or the use of the drug does not meet the definition for unnecessary utilization of a brand name drug as defined in this section. The MCO is responsible for determining when this unnecessary utilization of service has taken place and if so, the dispensing pharmacy is responsible for collecting the co-payment from the member.

(2) The unnecessary utilization of a brand name drug shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision. The MCO shall develop a co-payment exception process, to be prior approved by MAD, for legend drugs when generic alternatives are not tolerated by a member.

[8.308.14.9 NMAC - N, 1-1-14]

8.308.14.10 CO-PAYMENT AMOUNTS IN MANAGED CARE PROGRAMS: The copayment amounts, the application and exemptions of copayments are determined by MAD. See CFR 447.56, *Limitations on Premiums and Cost Sharing*, 8.200.430 NMAC and 8.302.2 NMAC.

HISTORY OF 8.308.14 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]