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8.315.4 PERSONAL CARE OPTION SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 315 OTHER LONG TERM CARE SERVICES
PART 4 PERSONAL CARE OPTION SERVICES

8.315.4.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.315.4.1 NMAC - Rp, 8.315.4.1 NMAC, 12-30-10]

8.315.4.2 SCOPE: The rule applies to the general public.
[8.315.4.2 NMAC - Rp, 8.315.4.2 NMAC, 12-30-10]

8.315.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.315.4.3 NMAC - Rp, 8.315.4.3 NMAC, 12-30-10]

8.315.4.4 DURATION: Permanent
[8.315.4.4 NMAC - Rp, 8.315.4.4 NMAC, 12-30-10]

8.315.4.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.315.4.5 NMAC - Rp, 8.315.4.5 NMAC, 12-30-10]

8.315.4.6 OBJECTIVE: The objective of this regulation is to provide rules for the service portion of the New Mexico medicaid program. These rules describe service delivery models, eligible providers and consumer and attendant responsibilities, covered and non-covered services, medical eligibility, assessments for services, individual plan of care (IPoC), utilization review, transfer process, consumer discharge, provider reimbursement, provider voluntary disenrollment, solicitation/advertising and sanction and remedies.
[8.315.4.6 NMAC - Rp, 8.315.4.6 NMAC, 12-30-10]

8.315.4.7 DEFINITIONS: [RESERVED]

8.315.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[8.315.4.8 NMAC - Rp, 8.315.4.8 NMAC, 12-30-10]

8.315.4.9 PERSONAL CARE OPTION SERVICES: Personal care option (PCO) services have been established by the New Mexico human services department (HSD), medical assistance division (MAD or medicaid) to assist individuals 21 years of age or older who are eligible for full medicaid coverage and meet the nursing facility (NF) level of care (LOC) criteria, see, *long term care services utilization review instructions for nursing facilities* which is attached to this part of the NMAC as attachment II. These regulations describe PCO services for consumers who are unable to perform at least two activities of daily living (ADLs) because of disability or functional limitation and need assistance with certain ADLs and instrumental activities of daily living (IADLs) as described in attachment I to this part of the NMAC.

A. A third-party assessor (TPA) determines medical LOC for PCO eligibility upon initial application and at least annually thereafter. Medicaid-eligible individuals may contact the TPA or the managed care organization (MCO) for coordinated long-term care services (CoLTS) (if applicable) to apply for PCO services.

B. The goals of PCO services are to avoid institutionalization and to maintain the individual's functional level and independence. Although an individual's assessment for the amount and types of services may vary, PCO services are not provided 24 hours a day.

C. PCO is a medicaid service, not a medicaid category of assistance, and services under this option are delivered pursuant to an IPoC. PCO services include a range of ADL and IADL services to consumers who are unable to perform at least two ADLs because of [~~a~~] disability or functional limitation(s). Consumers will be assessed for services at least annually, or more frequently, as appropriate. PCO services will not include those services for tasks the individual is already receiving from other sources including tasks provided by natural supports. Natural supports are friends, family, and the community (through individuals, clubs and organizations) that are able

and consistently available to provide supports and services to the consumer. The PCO service assessment is conducted pursuant to 8.315.4.19 NMAC, *assessments for services.* The PCO service assessment is performed by the TPA for fee-for-service (FFS) or the MCO for CoLTS and determines the amount and type of services needed to supplement the services a consumer is already receiving including those services provided by natural supports. PCO services must be related to the individual's functional level to perform ADLs and IADLs as indicated in the PCO service assessment and applied to the PCO service guide, MAD 055. The MAD 055 is attached to this part of the NMAC as attachment I.
[8.315.4.9 NMAC - Rp, 8.315.4.9 NMAC, 12-30-10; A, 9-15-11]

8.315.4.10 SERVICE DELIVERY MODELS:

A. Individuals eligible for PCO services have the option of choosing the consumer-delegated or the consumer-directed personal care model. Under both models, the consumer may select a family member (except a spouse), friend, neighbor, or other individual as the attendant. Under the consumer-delegated model, the consumer chooses the PCO agency to perform all employer-related tasks and the agency is responsible for ensuring all service delivery to the consumer. The consumer-directed model allows the consumer to oversee his/her own service care delivery, and requires the consumer to work with a PCO agency that acts as a fiscal intermediary agency to process all financial paperwork to medicaid for FFS or the MCO for consumers enrolled in CoLTS. The TPA for FFS or MCO for CoLTS, or other medicaid designee is responsible for explaining both models to each individual initially and annually thereafter.

B. Consumers who are unable to make a decision regarding the service delivery model or are unable to communicate decisions must have a legal representative to select and participate in the consumer-directed model. A legal representative is a person who has documentation that he or she is legally authorized to make decisions on behalf of the consumer. Examples include a properly executed Power of Attorney, legal guardian or conservator. A person's status as a legal representative must be properly documented with the PCO agency. If a consumer or the consumer's legal representative chooses consumer-directed personal care, the consumer or the consumer's legal representative retains responsibility for performing certain employer-related tasks. Alternatively, PCO services consumers may select an agency to provide services and perform employer related tasks, known as consumer-delegated personal care. The selected agency must be certified by medicaid or medicaid's designee to perform these tasks.

C. Regardless of which service delivery model is selected by the consumer or the consumer's legal representative, the consumer may hire family members (excluding spouses); however, a family member shall not be reimbursed for a service that he/she would have otherwise provided. A personal care attendant that resides with the consumer, regardless of any family relation, may not be paid to deliver household services, support services (shopping and errands), or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., cleaning consumer's room, linens, clothing, and special diets).
[8.315.4.10 NMAC - Rp, 8.315.4.10 NMAC, 12-30-10]

8.315.4.11 CONSUMER'S RESPONSIBILITIES: Consumers receiving PCO services have certain responsibilities depending on the service delivery model they choose.

A. The consumer's or consumer's legal representative's responsibilities under the **consumer-delegated model** include:

(1) verifying that services have been rendered by signing accurate time sheets/logs being submitted to the PCO agency for payroll;

(2) taking the medical assessment form (MAD 379) once a year to his/her physician (a physician's assistant, nurse practitioner or clinical nurse specialist may also sign the MAD 379 in the place of a physician for PCO services only) for completion and submitting the completed form and a current history and physical (H&P) completed within 12 months of the assessment date to the TPA for FFS or the MCO for CoLTS for review by the TPA; this must be done as required prior to the expiration of the approved NF LOC to ensure that there will be no break in services; a consumer who does not submit a timely MAD 379 and current H&P to the TPA for FFS or the MCO for CoLTS to forward to the TPA, may experience a break in services; in addition, the consumer must allow the TPA for FFS and the MCO for CoLTS, as applicable, to complete assessment visits and other contacts necessary to avoid a break in services;

(3) participating in the development and review of the IPoC;

(4) maintaining proof of current vehicle insurance (as mandated by the laws of the state of New Mexico) if the attendant will transport the consumer in the consumer's vehicle for support services that have been allocated to the consumer; and

(5) complying with all medicaid rules, regulations, and PCO service requirements; failure to comply could result in discontinuation of PCO services.

B. The consumer's or the consumer's legal representative's responsibilities under the **consumer-directed model** include:

(1) interviewing, hiring, training, terminating and scheduling personal care attendants; this includes, but is not limited to:

(a) verifying that the attendant possesses a current and valid state driver's license if there are any driving-related activities listed on the IPoC; a copy of the current driver's license must be maintained in the attendant's personnel file at all times; if no driving-related activities are listed on the IPoC, a copy of a valid state ID is kept in the attendant's personnel file at all times;

(b) verifying that the attendant has proof of current liability vehicle insurance if the consumer is to be transported in the attendant's vehicle at any time; a copy of the current proof of insurance must be maintained in the attendant's personnel file at all times; and

(c) identifying training needs; this includes training his/her own attendant(s) or arranging for training for the attendant(s);

(2) developing a list of attendants who can be contacted when an unforeseen event occurs that prevents the consumer's regularly scheduled attendant from providing services; making arrangements with attendants to ensure coverage and notifying the agency when arrangements are changed;

(3) verifying that services have been rendered by completing, dating, signing and submitting documentation to the agency for payroll; a consumer or his/her legal representative is responsible for ensuring the submission of accurate timesheets/logs; payment shall not be issued without appropriate documentation;

(4) notifying the agency, within one working day, of the date of hire or the date of termination of his/her attendant and ensure that all relevant employment paperwork and other applicable paperwork is completed and submitted; this may include, but is not limited to: employment application, verification from the employee abuse registry, criminal history screening, doctor's release to work (when applicable), photo identification, proof of eligibility to work in the United States (when applicable), copy of a state driver's license and proof of insurance (as appropriate);

(5) notifying and submitting a report of an incident (as described in Paragraph (14), Subsection B of 8.315.4.12 NMAC) to the PCO agency within 24 hours of such incident, so that the PCO agency can submit an incident report on behalf of the consumer; the consumer or his/her legal representative is responsible for completing the incident report;

(6) ensuring that the individual selected for hire has submitted [~~to~~] a request for a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq. of the Caregivers Criminal History Screening Act, within 20-calendar days of the individual beginning employment; the consumer must work with the selected agency to complete all paperwork required for submitting to the nationwide caregiver criminal history screening; the consumer may conditionally (temporarily) employ the individual contingent upon the receipt of written notice that the individual has submitted to a nationwide caregiver criminal history screening; a consumer may not continue employing an attendant who does not successfully pass a nationwide criminal history screening;

(7) obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCO services while under the influence of drugs or alcohol and, therefore, acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated and a copy of the signed agreement must be given to the PCO agency;

(8) ensuring that if the attendant is the consumer's legal representative and is the individual selected for hire, prior approval has been obtained from medicaid or its designee; any PCO services provided by the consumer's legal representative *MUST* be justified, in writing, by the PCO agency and consumer and submitted for approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure services were provided; documentation of written approval by medicaid or its designee must be maintained in the consumer's file; the consumer is responsible for immediately informing the agency if the consumer has appointed or obtained a legal representative any time during the plan year;

(9) signing an agreement accepting responsibility for all aspects of care and training including mandatory training in cardiopulmonary resuscitation (CPR) and first aid for all attendants, competency testing,

tuberculosis (TB) testing, hepatitis B immunizations or waiving the provision of such training and accepting the consequences of such a waiver;

(10) verifying initially prior to employment, and annually thereafter, that attendants are not on the employee abuse registry by researching the Consolidated Online Registry (COR) pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA, Section 27-7A-1 et seq.;

(11) taking the medical assessment form (MAD 379) or successor document once a year to his/her physician (physician's assistant, nurse practitioner or clinical nurse specialist) for completion and submitting the completed form and current H&P to the TPA for FFS or MCO for CoLTS, as applicable, for review; this must be done at least 60 days prior to the expiration of the approved NF LOC to ensure that there will be no break in services; a consumer who does not submit a timely MAD 379 and current H&P may experience a break in service; in addition, the consumer must allow the TPA for FFS and the MCO for CoLTS, as applicable, to complete assessment visits and other contacts necessary to avoid a break in services;

(12) participating in the development and review of the IPoC;

(13) maintaining proof of current vehicle insurance (as mandated by the laws of the state of New Mexico) if the attendant will transport the consumer in the consumer's vehicle for support services that have been allocated to the consumer;

(14) a consumer that authorizes services when he/she does not have a currently approved LOC or IPoC is liable for payment of those services, that are not eligible for medicaid reimbursement; and

(15) complying with all medicaid rules, regulations, and PCO service requirements; failure to comply could result in discontinuation of PCO services.

C. Consumers may have a personal representative assist him/her giving instruction to the personal care attendant or provide information to the TPA or MCO during assessments of the consumer's natural supports and service needs. A personal representative is not the same as a legal representative, but may be the same person, as appropriate. A personal care representative must have the following qualifications: be at least 18 years of age, have a personal relationship with the consumer and understand the consumer's natural supports and service support needs, and know the consumer's daily schedule and routine (to include medications, medical and functional status, likes and dislikes, strengths and weaknesses). A personal representative does not make decisions for the consumer unless he/she is also a legal representative, but may assist the consumer in communicating, as appropriate. A personal representative may not be a personal care attendant, unless he/she is also the legal representative and has obtained written approval from MAD or its designee pursuant to these PCO regulations. A person's status as a personal representative must be properly documented with the PCO agency.

[8.315.4.11 NMAC - Rp, 8.315.4.11 NMAC, 12-30-10; A, 9-15-11]

8.315.4.12 ELIGIBLE PCO AGENCIES: PCO agencies electing to participate in providing PCO services must obtain certification and have various responsibilities for complying with the requirements for provision of PCO services.

A. **PCO agency certification:** A PCO agency providing either the consumer-directed, the consumer-delegated or both models, must adhere to the requirements of this section. PCO agencies must be certified by medicaid or its designee. An agency listing, by county, is maintained by medicaid or its designee. All certified PCO agencies are required to select a county in which to establish and maintain an official office for conducting of business with published phone number and hours of operation; the PCO agency must provide services in all areas of the county in which the main office is located. The PCO agency may elect to serve any county within 100 miles of the main office. The PCO agency may elect to establish branch office(s) within 100 miles of the main office. The PCO agency must provide PCO services to all areas of any county(ies) selected to provide services. To be certified by medicaid or its designee, agencies must meet the following conditions and submit a packet (contents of paragraphs one through six described below) for approval to medicaid's fiscal agent or its designee containing the following:

(1) a completed medicaid provider participation agreement (PPA also known as the MAD 335);

(2) copies of successfully passed nationwide caregivers criminal history screenings on employees who meet the definition of "caregiver" and "care provider" pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act;

(3) a copy of a current and valid business license or documentation of non-profit status; if certified, a copy of the business license or documentation of non-profit status must be kept current and submitted annually;

(4) proof of liability and workers' compensation insurance; if certified, proof of liability and workers' compensation insurance must be submitted annually;

(5) a copy of written policies and procedures that address:

(a) medicaid's PCO provider rules and regulations;
(b) personnel policies; and
(c) office requirements that include but are not limited to:
(i) contact information, mailing address, physical location if different from mailing address, and hours of operation for the main office and branch offices if any; selected counties for the area(s) of service;
(ii) meeting all Americans with Disabilities Act (ADA) requirements; and
(iii) if PCO agencies have branch offices, the branch office must have a qualified on-site administrator to handle day-to-day operations who receives direction and supervision from the main/central office;
(d) quality improvement to ensure adequate and effective operation, including documentation of quarterly activity that addresses, but is not limited to:
(i) service delivery;
(ii) operational activities;
(iii) quality improvement action plan; and
(iv) documentation of quality improvement activities;
(e) agency operations to furnish services either as a consumer-directed or as a consumer-delegated, or both;

(6) a copy of a current and valid home health license, issued by the department of health, division of health improvement, licensing and certification (pursuant to 7.28.2 NMAC) may be submitted in lieu of requirements Paragraph (3) and Subparagraphs (b) and (d) of Paragraph (5) above; if certified, a copy of a current and valid home health license must be submitted annually along with proof of liability and workers' compensation insurance;

(7) if the agency requests approval to provide the consumer-delegated model of service, a copy of the agency's written competency test for attendants approved by medicaid or its designee; an agency may select to purchase a competency test or it may develop its own test; the test must address at least the following:
(a) communication skills;
(b) patient/client rights, including respect for cultural diversity;
(c) recording of information for patient/client records;
(d) nutrition and meal preparation;
(e) housekeeping skills;
(f) care of the ill and disabled, including the special needs populations;
(g) emergency response (including CPR and first aid);
(h) universal precautions and basic infection control;
(i) home safety including oxygen and fire safety;
(j) incident management and reporting; and
(k) confidentiality;

(8) after the packet is received, reviewed, and approved in writing by medicaid or its designee, the agency will be contacted to complete the rest of the certification process; this will require the agency to:
(a) attend a mandatory medicaid or its designee's provider training session prior to the delivery of PCO services; and
(b) possess a letter from medicaid or its designee changing provider status from "pending" to "active";

(9) an agency will not be certified as a personal care agency if:
(a) it is owned in full or in part by a professional authorized to complete the medical assessment form (MAD 379) or other similar assessment tool subsequently approved by medicaid under PCO or the agency would have any other actual or potential conflict of interest; or
(b) the agency is authorized to carry out PCO TPA responsibilities, such as in-home assessments, or the agency would have any other actual or potential conflict of interest; and
(c) a conflict of interest is presumed between people who are related within the third degree of blood or consanguinity or when there is a financial relationship between:
(i) persons who are related within the third degree of consanguinity (by blood) or affinity (by marriage) including a person's spouse, children, parents (first degree by blood); siblings, half-siblings, grandchildren or grandparents (second degree by blood and uncles, aunts, nephews, nieces, great grandparents, and great grandchildren (third degree by blood); stepmother, stepfather, mother-in-law, father-in-law (first degree by marriage); stepbrother, stepsister, brothers-in-law, sisters-in-law, step grandchildren, grandparents (second degree by

marriage); step uncles, step aunts, step nephews, step nieces, step great grandparents, step great grandchildren (third degree by marriage);

(ii) persons or entities with an ongoing financial relationship with each other including a personal care provider whose principals have a financial interest in an entity or financial relationship with a person who is authorized to complete an [~~ISD 379~~] MAD 379 or other similar assessment tool or authorized to carry out any of the TPA's responsibilities; a financial relationship is presumed between spouses.

B. **Approved PCO agency responsibilities:** A personal care agency electing to provide PCO services under either the consumer-directed model or the consumer-delegated model, or both, is responsible for:

(1) furnishing services to medicaid consumers that comply with all specified medicaid participation requirements outlined in 8.302.1 NMAC, *General Provider Policies*;

(2) verifying every month that all consumers are eligible for full medicaid coverage and PCO services prior to furnishing services pursuant to Subsection A of 8.302.1.11 NMAC, *provider responsibilities and requirements*; PCO agencies must document the date and method of eligibility verification; possession of a medicaid card does not guarantee a consumer's financial eligibility because the card itself does not include financial eligibility, dates or other limitations on the consumer's financial eligibility; PCO agencies must notify consumers who are not financially eligible that he/she cannot authorize employment for his/her attendant(s) until financial eligibility is resumed; PCO agencies and consumers cannot bill medicaid or its designee for PCO services rendered to the consumer if he/she is not eligible for PCO services;

(3) maintaining appropriate recordkeeping of services provided and fiscal accountability as required by the PPA;

(4) maintaining records, as required by the PPA and as outlined in 8.302.1 NMAC, *General Provider Policies*, that are sufficient to fully disclose the extent and nature of the services furnished to the consumers;

(5) passing random and targeted audits, conducted by medicaid or its designee, that ensure agencies are billing appropriately for services rendered; medicaid or its designee will seek recoupment of funds from agencies when audits show inappropriate billing or inappropriate documentation for services;

(6) providing either the consumer-directed or the consumer-delegated models, or both models;

(7) furnishing their consumers, upon request, with information regarding each model; if the consumer chooses a model that an agency does not offer, the agency must refer the consumer to medicaid or medicaid's designee for a list of agencies that offer that model; the TPA for FFS or the MCO for CoLTS is responsible for explaining each model in detail to consumers on an annual basis;

(8) ensuring that each consumer receiving PCO services has a current, approved IPoC on file;

(9) performing the necessary nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq. of the Caregivers Criminal History Screening Act, on all potential personal care attendants; nationwide caregiver criminal history screenings must be performed by an agency certified to conduct such checks; the agency, along with the consumer, as applicable ensures the paperwork is submitted within the first 20-calendar days of hire; consumers under the consumer-directed model or agencies under the consumer-delegated model may conditionally (temporarily) employ an attendant until such check has been returned from the certified agency; if the attendant does not successfully pass the nationwide caregiver criminal history screening, the agency under consumer-delegated or the consumer under consumer-directed may not continue to employ the attendant;

(10) producing reports or documentation as required by medicaid or its designee;

(11) verifying that consumers will not be receiving services through the following programs while they are receiving PCO services: medicaid home and community-based services (HCBS) waivers with the exception of the CoLTS (c) HCBS waiver, also known as the disabled and elderly (D&E) HCBS waiver, medicaid certified nursing facility (NF), intermediate care facility/mentally retarded (ICF/MR), program of all-inclusive care for the elderly (PACE), or adult protective services (APS) attendant care program; an individual residing in a NF or ICF/MR or receiving a non-qualifying HCBS waiver is eligible to apply for PCO services; recipients of community transition goods or services may also receive PCO services; all individuals must meet the medicaid and LOC eligibility requirements to receive PCO services; the TPA, medicaid, or its designee must conduct an assessment or evaluation to determine if the transfer is appropriate and if PCO services would be able to meet the needs of that individual;

(12) processing all claims for PCO services in accordance with the billing specifications from medicaid for FFS or the MCO for CoLTS, as appropriate; payment shall not be issued without appropriate documentation;

(13) making a referral to an appropriate social service, legal, or state agency, or the MCO for CoLTS for assistance, if the agency questions whether the consumer is able to direct his/her own care or is non-compliant with medicaid rules and regulations;

(14) immediately reporting abuse, neglect or exploitation pursuant to NMSA 1978, Section 27-7-30 and in accordance with the Adult Protective Services Act, by fax, within 24 hours of the incident being reported to the agency; reportable incidents may include but are not limited to abuse, neglect and exploitation as defined below:

(a) abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a consumer;

(b) neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer;

(c) exploitation is defined as the deliberate misplacement or wrongful, temporary or permanent use of a consumer's belongings or money without the voluntary and informed consent of the consumer;

(15) submitting written incident reports to medicaid or its designee, and the MCO for CoLTs consumers, on behalf of the consumer, within 24 hours of the incident being reported to the PCO agency; the PCO agency must provide the consumer with an appropriate form for completion; reportable incidents may include, but are not limited to:

(a) death of the consumer:

(i) unexpected death is defined as any death of an individual caused by an accident, or an unknown or unanticipated cause;

(ii) natural/expected death is defined as any death of an individual caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death;

(b) other reportable incidents:

(i) environmental hazard is defined as an unsafe condition that creates an immediate threat to life or health of a consumer;

(ii) law enforcement intervention is defined as the arrest or detention of a person by a law enforcement agency, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility;

(iii) emergency services refers to admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care that is not anticipated for this consumer and that would not routinely be provided by a primary care provider;

(iv) any reports made to APS;

(16) informing the consumer and his/her attendant of the responsibilities of the agency;

(17) develop an IPoC based on the assessment, services authorization, task list, and consideration of natural supports provided by the TPA for FFS or MCO for CoLTS;

(18) provide an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;

(19) identifying a consumer with an improved or declining health condition or whose needs have changed (i.e. more or less natural supports) and believe the consumer is in need of more or fewer services should send written notification to the TPA for an LOC determination and the TPA for FFS or MCO for CoLTS for additional assessment of need of services;

(20) except for the CoLTS (c) HCBS waiver, agencies who are providing PCO services to a consumer who becomes eligible for a non-CoLTS (c) HCBS waiver must coordinate with the consumer's service coordinator to ensure that the consumer does not experience a break in service or that services do not overlap; coordination must include the effective date PCO services are to stop and non-CoLTS (c) HCBS waiver services are to begin;

(21) maintaining documentation in the consumer's file regarding legal and personal representatives, as applicable; and

(22) cooperating with the TPA or MCO in locating and assisting the consumer with submitting the necessary paperwork for an LOC determination.

C. **For agencies providing PCO services under the consumer-directed model**, the responsibilities include:

(1) providing services through an agency with choice model or as a fiscal employer agent, and complying with all applicable state and federal employment laws as applicable to the provision of such services;

(a) agency with choice, in which the agency is the legal employer of the personal care attendant and the consumer is the managing employer and the agency maintains at least quarterly in-person contact with the consumer, or

(b) fiscal employer agent (FEA) in which the consumer is the legal employer of record and the managing employer; and the agency maintains at least quarterly in person contact with the consumer;

(2) obtaining from the consumer or his/her legal representative a signed agreement with the attendant in which the attendant agrees that he/she will not provide PCO services while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated; the agency must maintain a copy of the signed agreement in the attendant's personnel file, for the consumer;

(3) obtaining a signed agreement from each consumer accepting responsibility for all aspects of care and training including mandatory training in CPR and first aid for all attendants, competency testing, TB testing, hepatitis B immunizations or a waiver of providing such training and accepting the consequences thereof, and supervisory visits are not included in the consumer-directed option; a copy of the signed agreement must be maintained in the consumer's file;

(4) verifying that if the consumer has selected the consumer's legal representative as the attendant, the consumer has obtained prior approval from medicaid or its designee; any personal care services provided by the consumer's legal representative *MUST* be justified, in writing, by the agency and consumer and submitted for approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure that services were provided; documentation of written approval by medicaid or its designee must be maintained in the consumer's file; the agency must inform the consumer that if the consumer is appointed or selects a legal representative any time during the plan year, the consumer must notify the agency immediately and the agency must ensure appropriate documentation is maintained in the consumer's file;

(5) establishing and explaining to the consumer the necessary payroll documentation needed for reimbursement of PCO services, such as time sheets/logs and tax forms;

(6) performing payroll activities for the attendants, such as, but not limited to, state and federal income tax, social security withholdings and make payroll liability payments as required;

(7) arranging for state of New Mexico unemployment coverage and workers' compensation insurance for all attendants;

(8) informing the consumer of available resources for necessary training, if requested by the consumer, in the following areas: hiring, recruiting, training, supervision of attendants, advertising, and interviewing techniques;

(9) making a referral to an appropriate social service agency, legal agency(s) or medicaid designee for assistance, if the agency questions whether the consumer is able to direct his/her own care; and

(10) maintaining a consumer file and an attendant personnel file for the consumer for a minimum of six years.

D. **For agencies providing PCO services under the consumer-delegated model,** the responsibilities include, but are not limited to the following:

(1) employing, terminating and scheduling qualified attendants;

(2) conducting or arranging for training of all attendants for a minimum of 12-hours per year; initial training must be completed within the first three months of employment and must encompass:

(a) an overview of PCO services;

(b) living with a disability or chronic illness in the community;

(c) CPR and first aid training; and

(d) a written competency test with a minimum passing score of 80 percent or better; expenses for all trainings are to be incurred by the agency; other trainings may take place throughout the year as determined by the agency; the agency must maintain in the attendant's file: copies of all trainings, certifications, and specialty training the attendant completed; CPR and first aid certifications must be kept current;

(e) documentation of all training must include at least the following information: name of individual taking training, title of the training, source of instruction, number of hours of instruction, and date instruction was given;

(f) documentation of competency testing must include at least the following: name of individual being evaluated for competency, date and method used to determine competency, and copy of the attendant's graded and passed competency test in the attendant's personnel file; special accommodations must be made for attendants who are not able to read or write or who speak/read/write a language other than English;

(3) developing and maintaining a procedure to ensure trained and qualified attendants are available as backup for regularly scheduled attendants and emergency situations; complete instructions regarding the consumer's care and a list of attendant duties and responsibilities must be available in each consumer's home;

(4) informing the attendant of the risks of hepatitis B infection per current department of health (DOH) recommendation or the center for disease control and prevention (CDC), as appropriate, and offering hepatitis B immunization at the time of employment at no cost to the attendant; attendants are not considered to be at risk for hepatitis B since only non-medical services are performed; therefore, attendants may refuse the vaccine; documentation of the immunization, prior immunization, or refusal of immunization by the attendant must be in the attendant's personnel file;

(5) obtaining a copy of the attendant's current and valid state driver's license or other current and valid state photo id, if the consumer is to be transported by the attendant, obtaining a copy of the attendant's current and valid driver's license and current motor vehicle insurance policy; maintaining copies of these documents in the attendant's personnel file at all times;

(6) complying with federal and state regulations and labor laws;

(7) preparing all documentation necessary for payroll;

(8) complying with all specified medicaid participation requirements outlined in 8.302.1 NMAC, *General Provider Policies*;

(9) maintaining records that are sufficient to fully disclose the extent and nature of the services furnished to the consumers as outlined in 8.302.1 NMAC, *General Provider Policies*;

(a) the PCO agency may elect to keep a log/check-off list, in addition to the timesheet, in the consumer's home, describing services provided on a daily basis; if a log/check-off list is maintained, the log must be compared with the weekly timesheet and copies of both the timesheet and the log/check-off list must be kept in the consumer's file;

(b) the PCO agency may elect to use an electronic system that attendants may use to check in and check out at the end of each period of service delivery; the system must produce records that can be audited to determine the time of services provided, the type of services provided, and a verification by the consumer or the consumer's legal representative, as appropriate; failure by a PCO agency to maintain a proper record for audit under this system will subject the PCO agency to recovery by medicaid of any undocumented or insufficiently documented claims;

(10) obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCO services while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated;

(11) ensuring that if the consumer has elected the consumer's legal representative as his/her attendant, the agency has obtained prior approval from medicaid or its designee; all PCO services provided by the consumer's legal representative *MUST* be justified in writing by the agency and consumer and submitted for approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and include a plan for oversight by the agency to assure service delivery; documentation of approval by medicaid or its designee must be maintained in the consumer's file; the agency must inform the consumer that if the consumer is appointed or selects a legal representative any time during the plan year, they must notify the agency immediately;

(12) establishing and explaining to all their consumers and all attendants the necessary documentation needed for reimbursement of PCO services;

(13) performing payroll activities for the attendants;

(14) providing state of New Mexico workers' compensation insurance for all attendants;

(15) conducting face-to-face supervisory visits in the consumer's residence at least once a month (12 per service plan year); each visit must be sufficiently documented in the consumer's file by indicating:

(a) date of visit;
(b) time visiting to include length of visit;
(c) name and title of person conducting supervisory visit;
(d) individuals present during visit;
(e) review of IPoC;
(f) identification of health and safety issues and quality of care provided by attendant, and
(g) signature of consumer or consumer's legal representative;

(16) maintaining an accessible and responsive 24-hour communication system for consumers to use in emergency situations to contact the agency;

(17) following current recommendations of DOH and CDC, as appropriate, for preventing the transmission of TB for attendants upon initial employment and as needed; and

(18) verifying initially prior to employment, and annually thereafter, that attendants are not on the employee abuse registry by researching COR pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA 1978, Section 27-7A-1 et seq.
[8.315.4.12 NMAC - Rp, 8.315.4.11 & 12 NMAC, 12-30-10; A, 9-15-11]

8.315.4.13 PERSONAL CARE ATTENDANT RESPONSIBLITIES: Personal care attendants providing PCO services for consumers electing either **consumer-directed or consumer delegated** must comply with the following responsibilities and requirements. They include:

A. being hired by the consumer (consumer-directed model) or the PCO agency (consumer-delegated model);

B. not being the spouse of a consumer pursuant to 42 CFR Section 440.167 and CMS state medicaid manual section 4480-D;

C. providing the consumer (consumer-directed) or the PCO agency (consumer-delegated) with proof of and copies of current/valid state driver's license or current/valid state photo ID and if the attendant will be transporting the consumer, current/valid driver's license and current motor vehicle insurance policy;

D. being 18 years of age or older;

E. ensuring that if the attendant is the consumer's legal representative and is the selected individual for hire, prior approval has been obtained from medicaid or its designee; any personal care services provided by the consumer's legal representative *MUST* be justified, in writing, by the PCO agency and consumer and submitted for written approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure that services were provided; documentation of approval by medicaid or its designee must be maintained in the consumer's file and submit appropriate documentation of time worked and services performed ensuring that he/she has signed his/her time sheet/log/check-off list verifying the services provided to the consumer;

F. successfully passing a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act, performed by an agency certified to conduct such checks; attendants are required to submit to a criminal history screening within the first 20-days of hire; an attendant may be conditionally hired by the agency contingent upon the receipt of written notice from the certified agency of the results of the nationwide criminal history screening; attendants who do not successfully pass a nationwide criminal history screening are not eligible for further PCO service employment;

G. ensuring while employed as an attendant he/she will not be under the influence of drugs or alcohol while performing PCO services; the attendant must complete and sign an agreement with the agency or consumer in which the attendant acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated;

H. may not be the consumer's personal representative, unless he/she is also the legal representative;

I. if the attendant is a member of the consumer's family, he/she may not be paid for services that would have otherwise been provided to the consumer; if the attendant is a member of the consumer's household, he/she may not be paid for household services, support services (shopping and errands), or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., cleaning consumer's room, linens, clothing, and special diets);

J. an attendant may not act as the consumer's legal representative, in matters regarding medical treatment, financial or budgetary decision making, unless the attendant has documentation authorizing the attendant to act in a legal capacity on behalf of the consumer;

K. following current recommendations of DOH and CDC, as appropriate for preventing the transmission of TB, and

L. for **consumer-delegated care only**, completing 12-hours of training yearly; the attendant must obtain certification of CPR and first aid training within the first three months of employment, and the attendant must maintain certification throughout the entire duration of providing PCO services; additional training will be based on the consumer's needs as listed in the IPoC; attendants are not required to be reimbursed for training time and must successfully pass a written personal care attendant competency test with 80 percent or better within the first three months of employment.
[8.315.4.13 NMAC - N, 12-30-10]

8.315.4.14 ELIGIBLE POPULATION: To be eligible for PCO services, consumers must meet all of the following criteria:

A. be a recipient of a full benefit medicaid category of assistance and, except for CoLTS (c) HCBS waiver, not be receiving other medicaid HCBS waiver benefits, medicaid NF, intermediate care facility/mentally retarded (ICF/MR) medicaid, PACE, or APS attendant care program , at the time PCO services are furnished; an individual residing in a NF or ICF/MR medicaid or receiving medicaid under a non-CoLTS (c) HCBS waiver is eligible to apply for PCO services to facilitate NF discharge; recipients of community transition goods or services may also receive PCO services; all individuals must meet the medicaid eligibility requirements to receive PCO services; the TPA, medicaid or its alternative designee must conduct an assessment or evaluation to determine if the transfer to PCO is appropriate and if the PCO services would be able to meet the needs of that individual;

B. be age 21 or older;

C. be determined to have met NF LOC by the TPA; and

D. comply with all medicaid and PCO regulations and procedures.

[8.315.4.14 NMAC - N, 12-30-10]

8.315.4.15 COVERAGE CRITERIA: PCO services have been established to assist individuals 21 years of age or older who are eligible for full medicaid benefits and meet the NF LOC criteria, see, *long term care services utilization review instructions for nursing facilities* which is attached to this part of the NMAC as attachment II. PCO services are defined as those tasks necessary to avoid institutionalization and maintain the consumer's functional level and independence. PCO services are for consumers who are unable to perform at least two ADLs because of disability or functional limitation and need assistance with certain ADLs and IADLs as described in Attachment II to this part of the NMAC. PCO services are allocated for a reasonable accommodation of tasks to be performed by a personal care attendant, but do not provide 24-hours per day services. A PCO service assessment conducted pursuant to 8.315.4.19 NMAC, *assessments for services*, determines the amount and type of services needed to supplement the services a consumer is already receiving including those services provided by natural supports. PCO services are not provided 24 hours a day and allocation of time and services must be directly related to an individual's functional level to perform ADLs and IADLs as indicated in the PCO service assessment and applied to the PCO service guide, MAD 055. The PCO service guide, MAD 055 is attached to this part of the NMAC as attachment I.

A. PCO services are usually furnished in the consumer's place of residence, except as otherwise indicated, and during the hours specified in the consumer's IPoC. Services may be furnished outside the residence only when appropriate and necessary and when not available through other existing benefits and programs, such as home health or other state plan or long-term care services. If a consumer is receiving hospice care, is a resident in an assisted living facility, shelter home, or room and board facility, the TPA for FFS or the MCO for CoLTS, will perform an assessment and ensure that the PCO services do not duplicate the services that are already being provided. If ADL or IADL services are part of the hospice or assisted living facility, shelter home, or room and board facility, as indicated by the contract or admission agreement signed by the consumer, PCO services cannot duplicate those services. Regulations for assisted living facilities may be found at 7.8.2 NMAC, *Assisted Living Facilities for Adults.*

B. PCO services are not furnished to an individual who is an inpatient or resident of a hospital, NF, ICF/MR, mental health facility, correctional facility, other institutional settings (except for recipients of community transition goods or services).

C. All consumers, regardless of living arrangements, will be assessed for natural supports. PCO services are not intended to replace natural supports. Service hours will be allocated, as appropriate, to supplement the natural supports available to a consumer. Consumers that reside with other adult household members, that are not receiving PCO services or are not disabled, will be presumed to have household services in the common/shared areas provided by the other adult residents, whether or not the adult residents are the selected personal care attendant. Personal care attendants that live with the consumer will not be paid to deliver household services, support services (shopping and errands), or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., cleaning consumer's room, linens, clothing, and special diets). If a consumer's living situation changes:

(1) such that there is no longer a shared living space with another consumer, he/she will be re-assessed for services that were allocated between multiple consumers in a shared household; or

(2) such that he/she begins sharing a living space with another consumer(s), all consumers in the new shared living space will be re-assessed to determine the allocation of services shared by all consumers residing in the household.

[8.315.4.15 NMAC - Rp, 8.315.4.13 NMAC, 12-30-10; A, 9-15-11]

8.315.4.16 COVERED SERVICES: PCO services are provided as described in Paragraphs (1) through (6) of Subsection D. PCO services will not include those services for tasks the individual does not need or is already receiving from other sources including tasks provided by natural supports. PCO services must be related to the individual's functional level to perform ADLs and IADLs as indicated in the PCO service assessment conducted pursuant to 8.315.4.19 NMAC, *assessments for services*, and applied to the PCO service guide, MAD 055. See attachment I.

A. Mobility assistance, either physical assistance or verbal prompting and cueing, may be provided during the administration of any PCO task by the attendant. Mobility assistance includes assistance with ambulation, transferring and repositioning which is defined as moving around inside or outside the residence or consumer's living area with or without assistive devices(s) such as walkers, canes and wheelchairs or turning or moving to another position to prevent skin breakdown.

B. Certain PCO services are provided only when the consumer has the ability to self-administer. Ability to self-administer is defined as the ability to identify and communicate medication name, dosage, frequency and reason for the medication. A consumer who does not meet this definition of ability to self-administer is not eligible for these services.

C. When two or more consumers living in the same residence (including assisted living facilities, shelter homes, and other similar living arrangements), are receiving PCO services, they will be assessed both individually and jointly to determine services that are shared. Consumers sharing living space will be assessed for services identified in Paragraphs (2) and (4) of Subsection D of 8.315.4.16 NMAC: assess each consumer individually to determine if the consumer requires unique assistance with the service; and jointly with other household members to determine shared living space and common needs of the household; services will be allocated based on common needs, not based on individual needs, unless assessed by the TPA for FFS or the MCO for CoLTS that there is an individual need for provision of the service(s) as indicated above; (common needs may include meals that can be prepared for several individuals; shopping/errands that can be completed at the same time; laundry that can be completed for more than one individual at the same time; dusting and vacuuming of shared living spaces); these PCO services are based on the assessment of combined needs in the household without replacing natural and unpaid supports identified during the assessment.

D. Description of PCO services.

(1) **Individualized bowel and bladder services:** These services include bowel care, bladder care, perineal care and toileting.

(a) Pursuant to NMSA 1978, Section 61-3-29(J) of the Nursing Practice Act, bowel and bladder care may be provided to a consumer that is medically stable and able to communicate and assess his/her own needs to include:

(i) bowel care - evacuation and ostomy care, changing and cleaning of bags and ostomy site skin care; an individual requiring assistance with bowel care who does not have a statement by his/her physician determining he/she is medically stable and able to communicate his/her bladder care needs is not eligible for PCO services in this category; digital stimulation is not a covered service; and

(ii) bladder care - cueing the consumer to empty his/her bladder at timed intervals to prevent incontinence; elimination; catheter care, including the changing and cleaning of the catheter bag; the requirements and limitations from Item (i) bowel care above regarding medically determined stability and ability to communicate apply here; insertion/extraction of a catheter is not a covered service.

(b) Services that do not require the consumer to be medically stable and able to communicate and assess his/her own needs include:

(i) perineal care - cleansing of the perineal area and changing of sanitary napkins; and

(ii) toileting - assisting with bedside commode or bedpan; cleaning perineal area, changing adult briefs/pads, readjusting clothing; cleaning changing of wet or soiled clothing after incontinence episodes or assisting with adjustment of clothing before and after toileting;

(c) mobility assistance to ensure appropriate bowel and bladder services.

(2) **Meal preparation and assistance:** At the direction of the consumer or his/her personal representative, prepare meal(s) including cutting ingredients to be cooked, cooking of meals, and placing/presenting meal in front of consumer to eat, and cutting up food into bite-sized portions for the consumer or assist the consumer pursuant to the IPoC. This includes provision of snacks and fluids and may include mobility assistance and prompting/cueing the consumer to prepare meals. This does not include assistance with eating. Services requiring assistance with eating are covered under eating in Paragraph (3) below. Personal care attendants who reside in the same household as the consumer may not be paid for meal preparation routinely provided as part of the household

division of chores, unless those services are specific to the consumer (i.e., special diets, processing of meals into edible portions, pureeing).

(3) **Eating:** Feeding the consumer or assisting the consumer with eating a prepared meal with a utensil or with specialized utensils is a covered service. Eating is the ability to physically put food into mouth, chew and swallow food safely. The attendant shall assist the consumer as determined by the IPoC. Eating assistance may include mobility assistance and prompting/cueing a consumer to ensure appropriate nutritional intake or monitor for choking. This does not include preparation of food/meals. Services requiring preparation of food/meals is covered under meal preparation and assistance in Paragraph (2). If the consumer has special needs in this area, the attendant should receive specific instruction to meet that need. Gastrostomy feeding and tube feeding are not covered services.

(4) **Household support services:** This service is for assisting/performing interior household activities as needed and other support services that provide additional assistance to the consumer. Interior household activities are limited to the maintenance of the consumer's personal living area (i.e., kitchen, living room, bedroom, and bathroom). To maintain a clean and safe environment for the consumer, particularly a consumer living alone who may not have adequate support in his/her residence. Assistance may include mobility assistance and prompting/cueing a consumer to ensure appropriate household support services. Personal care attendants who reside in the same household as the consumer 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 consumer (i.e., changing the consumer's linens, cleaning the consumer's personal living areas). Services include:

(a) sweeping, mopping or vacuuming the consumer's carpets, hardwood floors, tile or linoleum;

(b) dusting the consumer's furniture;

(c) changing the consumer's linens;

(d) washing the consumer's laundry;

(e) cleaning the consumer's bathroom (tub or shower area, sink, and toilet);

(f) cleaning the consumer's kitchen and dining area (i.e., washing the consumer's dishes, putting the consumer's dishes away; cleaning counter tops, cleaning the area where the consumer eats, etc.); household services do not include cleaning up after other household members or pets;

(g) minor cleaning of assistive device(s), wheelchair and durable medical equipment (DME) is a covered service; a consumer must have an assistive device(s) that requires regular cleaning (that is not already provided by the supplier of the assistive device) that the consumer cannot clean to be eligible to receive services under this category;

(h) shopping or completing errands specific to the consumer (with or without the consumer);

(i) transportation of the consumer - transportation shall only be for non-medically necessary events and may include assistance with transfers in/out of vehicles; PCO agencies are not required to provide this service; consumers that need this service and are with a PCO agency that does not provide this service may transfer to a different PCO agency in accordance with 8.315.4.22 NMAC, *transfer process for PCO services;* medically necessary transportation services may be a covered PCO service when the TPA for FFS or the MCO for CoLTS has assessed and determined that other medically necessary transportation services are not available through other state plan services;

(j) assistance with feeding and hydrating or cueing consumer to feed and hydrate a personal assistance animal for the consumer is a covered service; a consumer must provide documentation that his/her animal is a personal assistance animal; feeding and hydrating non-assistance animals is not a covered service;

(k) assistance with battery replacement and minor, routine wheelchair and durable medical equipment (DME) maintenance is a covered service; a consumer must have an assistive device(s) that requires regular maintenance (that is not already provided by the supplier of the assistive device) that the consumer cannot maintain in order to be eligible to receive services under this category; and

(l) assistance with self-administering physician ordered (prescription) medications is limited to *prompting and reminding only;* the use of over the counter medications does not qualify for this service; a consumer must meet the definition of "ability to self-administer" defined in this section, to be eligible to receive time for this task; a consumer who does not meet the definition of ability to self-administer is not eligible for this service; this assistance does not include administration of injections, which is a skilled/nursing task; splitting or crushing medications or filling medication boxes is not a covered service; assistance includes:

(i) getting a glass of water or other liquid as requested by the consumer for the purpose of taking medications;

(ii) at the direction of the consumer, handing the consumer his/her daily medication box or medication bottle; and

(iii) at the direction of the consumer, helping a consumer with placement of oxygen tubes for consumers who can communicate to the caregiver the dosage/route of oxygen.

(5) **Hygiene/grooming:** The IPoC may include the following tasks to be performed by the attendant or cueing and prompting by the attendant for the consumer to perform the tasks. These services include:

(a) bathing - giving a sponge bath/bed bath/tub bath/shower, including transfer in/out, turning bath/shower water off/on, and setting temperature of bath/shower water; bringing in water from outside or heating water for consumer;

(b) dressing - putting on, fastening, removing clothing, and shoes;

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

(d) oral care with intact swallowing reflex - brushing teeth, cleaning dentures/partials (includes use of floss, swabs, or mouthwash);

(e) nail care - cleaning, filing to trim, or cuticle care, except for consumers with a medical condition such as venous insufficiency, diabetes, peripheral neuropathy, or consumers that are documented as medically at risk, which then would be considered a skilled task and not a covered PCO service;

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

(g) physician ordered skin care – the consumer must have a skin disorder documented by a physician, physician assistant, nurse practitioner or a clinical nurse specialist to be eligible to receive skin care services; this service is limited to the attendant's application of over-the counter or prescription skin cream for a diagnosed chronic skin condition that is not related to burns, pressure sores or ulceration of skin; a consumer must meet the definition of "ability to self-administer" defined in this section, to be eligible to receive time for application of a prescription over-the counter medication for skin care; wound care/open sores and debriding/dressing open wounds are not covered services;

(h) prompting/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.

(6) **Supportive mobility assistance:** Physical or verbal prompting and cueing mobility assistance provided by the attendant that are not already included as part of other PCO service tasks. These include assistance with:

(a) ambulation - moving around inside or outside the residence or consumer's living area with or without assistive device(s) such as walkers, canes and wheelchairs;

(b) transferring - moving to/from one location/position to another with or without assistive devices(s) including in and out of vehicles;

(c) toileting - transferring on/off toilet; and

(d) repositioning - turning or moving an individual to another position who is bed bound to prevent skin breakdown.

[8.315.4.16 NMAC - Rp, 8.315.4.14 NMAC, 12-30-10; A, 9-15-11]

8.315.4.17 NON-COVERED SERVICES: The following services are not covered as New Mexico medicaid PCO services:

A. services to an inpatient or resident of a hospital, NF, ICF/MR, mental health facility, correctional facility or other institutional setting, except for recipients of community transition goods or services;

B. services that are already being provided by other sources including natural supports;

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

D. services that must be provided by a person with professional licensure or technical training;

E. services not approved in the consumer's approved IPoC;

F. childcare, pet care or personal care for other household members not receiving PCO services;

G. retroactive services;

H. services provided to a consumer who does not have medicaid eligibility;

I. assistance with finances and budgeting;

J. scheduling of appointments for a consumer;

K. range of motion exercises;

L. wound care/open sores and debriding/dressing open wounds;

M. filling of medication boxes, cutting/grinding pills, administration of injections, assistance with over-the-counter medication or medication that the consumer cannot self-administer;

N. skilled nail care for consumers with a medical condition such as venous insufficiency, diabetes, peripheral neuropathy, or consumers that are documented as medically at risk;

O. medically necessary transportation available through other state plan services;

P. bowel and bladder services that include insertion/extraction of a catheter or digital stimulation; and

Q. gastrostomy feeding and tube feeding.

[8.315.4.17 NMAC - Rp, 8.315.4.15 NMAC, 12-30-10]

8.315.4.18 MEDICAL ELIGIBILITY: To be eligible for PCO services, a consumer must meet the LOC required in a NF.

A. The TPA is responsible for making LOC determinations based on criteria developed by medicaid or medicaid's designee according to national standards. See attachment II to this part titled *long term care services utilization review instructions for nursing facilities*.

(1) **Determine level of care (LOC):** The TPA makes initial LOC determinations and subsequent determinations at least annually thereafter.

(a) An LOC packet is developed by the TPA for FFS and the MCO for CoLTS and reviewed by the TPA to determine approval for medical eligibility.

(b) The LOC packet must include:

(i) a current (within the last six months) approved medical assessment form (MAD 379) signed by a physician or physician's designee (physician assistant, nurse practitioner or, clinical nurse specialist);

(ii) a current H&P: a H&P is current when the date of service is not more than 12 months from the date the medical provider completed the MAD 379 medical assessment form; documentation of the H&P is any documentation that is consistent with a reimbursable medicare/medicaid H&P provider claim; this includes documentation of the evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations(s), laboratory/diagnostic procedures;

(iii) any other information or medical justification documenting the consumer's functional abilities; and

(iv) an assessment of the consumer's functional needs, performed by the TPA initially through the in-home assessment (MAD 057), or for subsequent approval, subsequent assessments performed by the TPA for FFS or MCO for CoLTS; for subsequent assessments, a current in-home assessment is one that is completed after a renewal notice is issued to a consumer and prior to the end of the annual LOC date span.

(2) **The TPA will use the LOC packet to:**

(a) make all LOC determinations for all consumers requesting/receiving PCO services;

(b) approve the consumer's LOC for a maximum of one year (12 consecutive months); and a new LOC determination must be made at least annually to ensure the consumer continues to meet medical eligibility criteria for PCO services; each LOC determination must be based on the consumer's current medical condition and need of service(s) and may not be based on prior year LOC determinations; the approved NF LOC has a start date and an end date of no more than 12 consecutive months, which is the NF LOC span; and

(c) contact the consumer for FFS or the MCO for CoLTS within a minimum of 120 days, prior to the expiration of the approved LOC, to begin the annual LOC review process for PCO services to prevent a break in service; the TPA for FFS or the MCO for CoLTS shall also provide a notification to the PCO agency, at the same time the consumer is notified, that the LOC is due to expire within 120 days.

(3) Any individual applying for PCO services who has an existing approved NF LOC in another program (i.e., CoLTS (c) waiver or nursing facility) will not need another LOC determination until his/her next annual NF LOC assessment.

B. **Initial in-home assessment:** The TPA must perform an initial in-home assessment (MAD 057) of the consumer's functional needs in the consumer's place of residence. The initial in-home assessment is only done one time by the TPA when the consumer is first evaluated for eligibility for PCO services and not upon annual renewal.

C. The TPA must initially explain both service delivery models, consumer-directed and consumer-delegated to the consumer or his/her legal representative and provide the consumer or his/her legal representative with informational material, allowing the consumer to make the best educated decision possible regarding which model he/she will select. A copy of the consumer's or legal representative's responsibilities in 8.315.4.10 NMAC,

service delivery models, must be provided to each consumer or legal representative. If the consumer is FFS, the TPA must explain both service delivery models and provide a copy of the consumer's responsibilities in 8.315.4.10 NMAC, *service delivery models*, at every annual assessment, based on the service delivery model he/she has selected.

D. A PCO agency that does not agree with the LOC determination made by the TPA or medicaid's designee may work with the consumer's physician or physician designee that submitted the MAD 379 form to request a re-review or reconsideration from the TPA pursuant to medicaid oversight policies, 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

E. A consumer that does not agree with the LOC determination made by the TPA may file a grievance with the TPA, or request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings*, or request both.

F. Conflict of interest: The TPA is not authorized to contract with any medicaid approved PCO agency to carry out TPA responsibilities or any person, agency, or entity that would have any other actual or potential conflict of interest as a TPA subcontractor due to its financial or corporate relationship or relationship by blood (consanguinity) or by affinity (by marriage) to the third degree with a PCO personal care provider agency or its principals. A conflict of interest includes the situation in which a principal or a relative of the principal of the prospective TPA contracting entity has a financial interest in a PCO provider agency.

G. Temporary authorization: If the consumer is determined to meet the medical eligibility criteria to receive PCO services, but is not yet enrolled in CoLTS, the TPA automatically gives these consumers a temporary prior-authorization of 10 hours per week for up to 75 days. This temporary prior-authorization is automatic for all CoLTS consumers that are medically eligible and is not a determination of a CoLTS consumer's actual need. The consumer's actual need may be higher or lower as determined by the assessment for services performed by the MCO for CoLTS. There is no right to a fair hearing with respect to this temporary prior authorization. The approval for 10 hours is not a guarantee of a minimum amount of services when the consumer is assessed by the MCO for CoLTS for need of services. Temporary prior authorization of services does not guarantee that an individual is eligible for medicaid. PCO agencies must verify monthly all individuals' financial eligibility for medicaid prior to providing services. FFS consumers do not receive a temporary authorization as their assessment of services is conducted at the same time as the LOC assessment.

H. The TPA shall review the LOC upon a referral from the PCO agency, the consumer the consumer's legal representative, or the MCO for CoLTS regarding an improvement or decline in the consumer's health condition and make a new determination regarding eligibility, as appropriate.

I. The completed MAD 379 form and H&P is used solely to determine the LOC and is not used to determine the type or the amount of PCO services for a consumer. The MAD 057 is used to obtain initial in-home assessment information on a consumer who is FFS or not yet enrolled in CoLTS.

[8.315.4.18 NMAC - N, 12-30-10; A, 9-15-11]

8.315.4.19 ASSESSMENTS FOR SERVICES: After the consumer is determined to be medically eligible for PCO services, the TPA for FFS or the MCO for CoLTS performs a PCO service assessment (assessment form approved by the state). Although an individual's assessment for the amount and types of services may vary, PCO services are not provided 24 hours a day. An individual's PCO services must be directly related to their functional level to perform ADLs and IADLs as indicated in the PCO service assessment and applied to the separate PCO service guide, MAD 055. The PCO service guide, MAD 055, is attached to this part of the NMAC as attachment I. Service assessments are performed when a consumer enters the program (initial assessment), at least annually (annual assessment) or in the interim (interim assessment) if certain criteria are met.

A. The service assessment (initial, interim, or annual) performed by the TPA for FFS or the MCO for CoLTS determines the type of covered services needed by the consumer. The amount of time allocated to each type of covered service is determined by applying and recording the individual's functional level to perform ADLs and IADLs from the service assessment, to the separate PCO service guide, MAD 055. PCO services are allocated for a reasonable accommodation of tasks to be performed by a personal care attendant. A PCO service assessment determines the amount and type of PCO services needed to supplement and not duplicate the services a consumer is already receiving including those services provided by natural supports. In the event that the consumer's functional needs exceed the average allocation of time allotted to perform a particular service task per the recommendation of a medical professional, the TPA for FFS or the MCO for CoLTS may consider authorizing additional time based on the consumer's verified medical and clinical need(s).

B. The service assessment and MAD 055 is conducted and discussed with the consumer in the consumer's place of residence by the TPA for FFS or the MCO for CoLTS and shall be based on the current health condition and functional needs of the consumer, to include no duplication of services a consumer is already

receiving including those services provided by natural supports, and shall not be based on a prior assessment of the consumer's health condition, functional needs, or existing services.

C. The completed service assessment and MAD 055 is sent to the PCO agency by the TPA for FFS or the MCO for CoLTS for the PCO agency to develop the IPoC.

D. The assessment must be performed by the TPA for FFS or the MCO for CoLTS upon a consumer's initial approval for medical NF LOC eligibility to receive PCO services (initial assessment) and at least annually thereafter (annual assessment). The annual assessment is completed prior to the expiration of the current NF LOC span and determines the type and amount of services for the subsequent NF LOC span. The type and amount of PCO services as determined by an annual assessment shall not be effective prior to the start of the applicable NF LOC span. The TPA for FFS or the MCO for CoLTS must complete an assessment within 75 days from the date of the temporary prior authorization. An interim assessment may be conducted if:

(1) there is a change in the consumer's condition (either improved or declined);
(2) there is a change in the consumer's natural supports or living conditions;
(3) upon the consumer's request;
(4) the full amount of services has not been utilized within the last two months; or
(5) upon a referral from a PCO agency regarding the consumer's need for an assessment.

E. The MCO must explain each service delivery model at least annually to consumers enrolled in CoLTS.

F. The TPA for FFS or the MCO for CoLTS will issue a prior authorization (PA) to the PCO agency. A PCO service authorization cannot extend beyond the LOC span and must be provided to the PCO agency prior to the PA effective date and not applied retroactively.

G. A PCO consumer who disagrees with the authorized number of hours may utilize the CoLTS MCO grievance and appeal process when enrolled in CoLTS and the state's fair hearing process pursuant to 8.352.2 NMAC, *Recipient Hearings*, or both. Requests for an MCO grievance/appeal and a state fair hearing may be filed consecutively or concurrently so long as each request is within the required time limitations for making such a request. The TPA for FFS or the MCO for CoLTS may schedule a pre-hearing conference with the consumer to explain how the PCO regulations were applied to the authorized service time and to attempt to resolve disagreements prior to the fair hearing.

(1) Continuation of benefits: A consumer may continue PCO benefits while an MCO grievance and appeal or state's fair hearing decisions are pending, pursuant to 8.352.2 NMAC, *Recipient Hearings*, if the member requests continuation of benefits within 13 calendar days of the date of the notice of action.

(2) The consumer may be responsible for repayment of the cost of the services furnished while the MCO grievance and appeal process or the state's fair hearing process was pending, to the extent that the services were furnished solely because of this requirement to provide continuation of benefits during the MCO grievance and appeal or state fair hearing process. The state for FFS or the MCO for CoLTS may recover these costs from the member and not the provider.

[8.315.4.19 NMAC - N, 12-30-10; A, 9-15-11]

8.315.4.20 INDIVIDUAL PLAN OF CARE (IPOC): An IPoC is developed and PCO services are identified along with the appropriate assessment for allocating PCO services. The PCO agency develops an IPoC using an MCO authorization, service assessment and the MAD 055 provided by the TPA for FFS or the MCO for CoLTS. The finalized IPoC must contain a seven-day schedule including the identification and documentation of natural support days not authorized for PCO services and authorized PCO attendant task days and tasks to be performed by the PCO caregiver. Only those services identified as IADLs, household support services or certain ADL PCO services such as meal preparation may be moved to another day, using the IPoC as a tool. The PCO agency must document more and less service time on the IPoC for specific day(s) during the week as long as the consumer has his/her daily needs met and the total weekly hours do not exceed the weekly task total. Consumers receiving services only a certain number of days of the week may not be allocated time for ADLs on days in which an attendant does not provide services, i.e., time will not be allocated for ADLs for seven days if a consumer receives services only four days during the week. Any tasks not performed by the attendant for any reason cannot be banked or saved for a later date.

A. The PCO agency must:

(1) develop the IPoC with a specific description of the attendant's responsibilities, including tasks to be performed by the attendant and any special instructions related to maintaining the health and safety of the consumer;

(2) ensure the consumer has participated in the development of the plan and that the IPoC is reviewed and signed by the consumer or the consumer's legal representative; a signature on the IPoC indicates that the consumer or the consumer's legal representative understands what services have been identified and that services will be provided on a weekly basis for a maximum of one year; if a consumer is unable to sign the IPoC and the consumer does not have a legal representative, a thumbprint or personal mark (i.e., an "X") will suffice; if signed by a legal representative, medicaid or its designee and the agency must have documentation in the consumer's file verifying the individual is the consumer's legal representative;

(3) maintain an approved IPoC for PCO services for a maximum of one year (12 consecutive months), a new IPoC must be developed at least annually, to ensure the consumer's current needs are being met; a consumer's previous year IPoC is not used or considered in developing a new IPoC and allocating services; a new IPoC must be developed independently at least every year based on the consumer's current medical condition and need of services; the tasks and number of hours in the IPoC must match the authorized tasks and number of hours on the authorization;

(4) provide the consumer and the TPA for FFS or MCO for CoLTS with a copy of their approved IPoC;

(5) obtain an approved task list and MAD 055 from the TPA for FFS or MCO for CoLTS;

(6) obtain written verification that the consumer or the consumer's legal representative understands that if the consumer does not utilize services (for two months) or the full amount of allocated services (within a two-month period) on the IPoC that these circumstances will be documented in the consumer's file for need of services; and

(7) submit a personal care transfer/closure form (MAD 062 or other approved transfer/closure form) to the TPA for FFS or MCO for CoLTS for a consumer who has passed away or who has not received services for 90-consecutive days.

B. PCO services are to be delivered in the state of New Mexico only. Consumers who require PCO services out of the state, for medically necessary reasons only, must obtain medicaid or medicaid's designee for FFS or the MCO for CoLTS written approval prior to leaving the state. The following must be submitted for consideration when requesting medically necessary out-of-state services:

(1) a letter from the consumer or the consumer's legal representative requesting an out-of-state exception and reason for request; the letter must include:

(a) the consumer's name and social security number;

(b) how time sheets/logs/check-off list will be transmitted and payroll checks issued to the attendant;

(c) date the consumer will be leaving the state, including the date of the medical procedure or other medical event, and anticipated date of return; and

(d) where the consumer will be housed after the medical procedure;

(2) a letter or documentation from the physician, surgeon, physician assistant, nurse practitioner, or clinical nurse specialist verifying the date of the medical procedure; and

(3) a copy of the consumer's approved IPoC and a proposed adjusted revision of services to be provided during the time the consumer is out-of-state; support services and household services will not be approved unless justified; if the consumer has been approved for services under self-administered medications, a statement from the physician, physician assistant, nurse practitioner, or clinical nurse specialist must be included indicating the consumer will continue to have the ability to self-administer for the duration he/she is out-of-state.

[8.315.4.20 NMAC - Rp, 8.315.4.17 NMAC, 12-30-10; A, 9-15-11]

8.315.4.21 UTILIZATION REVIEW (UR): All PCO services are subject to utilization review for medical necessity and program compliance. See 8.302.5 NMAC, *Prior Authorization and Utilization Review.* All PCO services require prior LOC approval by the TPA; therefore, retroactive services are not authorized. The TPA for FFS or the MCO for CoLTS will perform utilization review for medical necessity. The TPA for FFS or the MCO for CoLTS makes final authorization of PCO services using:

A. the TPA-approved LOC determination; and

B. an assessment conducted by the TPA for FFS or the MCO for CoLTS to include the MAD 055.

[8.315.4.21 NMAC - Rp, 8.315.4.18 NMAC, 12-30-10]

8.315.4.22 TRANSFER PROCESS FOR PCO SERVICES: A consumer wishing to transfer services to another medicaid approved PCO agency may request to do so. Transfers within the plan year may be requested by the consumer, but must be approved by medicaid or medicaid's designee prior to the agency providing PCO services

to the consumer. All requests for change of service model (from directed/delegated) must be approved by the TPA for FFS or MCO for CoLTS prior to the receiving agency providing services to the consumer. Transfers may only be initiated by the consumer or his/her legal representative and may not be requested by the attendant as a result of an employment issue. For consumers enrolled in a CoLTS MCO, the transfer process is determined by medicaid or medicaid's designee and should be initiated by the consumer through the consumer's assigned service coordinator. The consumer must give the reason for the requested transfer.

A. A transfer requested by a consumer may be denied by medicaid or its designee for the following reasons:

(1) the consumer is requesting more hours/services;

(2) the consumer's attendant or family member is requesting the transfer;

(3) the consumer has requested three or more transfers within a six-month period;

(4) the consumer wants his/her legal guardian, spouse or attorney-in-fact to be his/her attendant;

(5) the consumer wants an individual to be his/her attendant who has not successfully passed a nationwide criminal history screening;

(6) the consumer wants an attendant who has been terminated from another agency for fraudulent activities or other misconduct;

(7) the attendant does not want to complete the mandated trainings under the consumer-delegated model;

(8) the consumer does not wish to comply with the medicaid or PCO regulations and procedures; and

(9) there is reason to believe that solicitation has occurred as defined in 8.315.4.24 NMAC, *reimbursement.*

B. The TPA for FFS or MCO for CoLTS will notify the consumer and both the originating agency and the receiving agency of its decision and has 15-working days after receiving the request from the TPA to make a decision. The consumer must work with the TPA for FFS or the MCO for CoLTS to verify his/her request.

C. A consumer who does not agree with the decision may request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings.* The originating agency is responsible for the continuance of PCO services as identified in Subsection G of 8.315.4.19 NMAC throughout the fair hearing process.

D. The following is the process for submitting a transfer request.

(1) The consumer must inform the TPA for FFS or the MCO for CoLTS of the desire to transfer PCO agencies; the TPA for FFS or the MCO for CoLTS approves or denies the transfer request; if approved, the TPA for FFS or the MCO for CoLTS works with both the agency he/she is currently receiving services from (originating agency) and the agency he/she would like to transfer to (receiving agency) to effectively complete the transfer.

(2) Originating agencies are responsible for continuing service provision until the transfer is complete.

(3) Both the originating and receiving PCO agencies are responsible for following approved transfer procedures (either TPA for FFS or MCO for CoLTS transfer procedures).

(4) After the TPA for FFS or the MCO for CoLTS verifies the consumer's request, the TPA for FFS or the MCO for CoLTS will process the transfer request within 15 working days of receiving the transfer request.

(5) The TPA for FFS or the MCO for CoLTS will issue a new prior authorization number and task information to the receiving agency and make the transfer date effective 10 business days from the date of processing the transfer request with new dates of service and units remaining for the remainder of the IPoC year; the TPA for FFS or the MCO for CoLTS will notify the consumer and the originating and receiving PCO agencies. [8.315.4.22 NMAC - Rp, 8.315.4.19 NMAC, 12-30-10; A, 9-15-11]

8.315.4.23 CONSUMER DISCHARGE: A consumer may be discharged from a PCO agency or may be discharged by the state from receiving any PCO services.

A. **PCO agency discharge:** The PCO agency may discharge a consumer for a justifiable reason. Prior to initiating discharge, the PCO agency must send a notice to medicaid or its designee for approval. Once approved by medicaid or its designee, the PCO agency may initiate the discharge process by means of a 30-day written notice to the consumer. The notice must include the consumer's right to request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings.* The notice must include the justifiable reason for the agency's decision to discharge.

(1) A PCO agency may discharge a consumer for a justifiable reason. A justifiable reason for discharge may include:

(a) staffing problems (i.e., excessive request for change in attendants (three or more in a 30-day period);

(b) a consumer demonstrates a pattern of verbal or physical abuse toward attendants or agency personnel, including the use of vulgar or explicit (i.e. sexually) language, sexual harassment, excessive use of force, use of verbal threats or physical threats, demonstrates intimidating behavior; the agency or attendant must have documentation demonstrating the pattern of abuse; the agency may also discharge a consumer if the life of an attendant or agency's staff member is believed to be in immediate danger;

(c) a consumer or family member demonstrates a pattern of uncooperative behavior including not complying with agency or medicaid regulations; not allowing the PCO agency to enter the home to provide services; and continued requests to provide services not approved on the IPoC;

(d) illegal use of narcotics or alcohol abuse; and

(e) fraudulent submission of timesheets; or

(f) living conditions or environment that may pose a health or safety risk or cause harm to the personal care attendant, employee of an agency, TPA, MCO, or other medicaid designee.

(2) The PCO agency must provide the consumer with a current list of medicaid-approved personal care agencies that service the county in which the consumer resides. The PCO agency must assist the consumer in the transfer process and must continue services throughout the transfer process. If the consumer does not select another PCO agency within the 30-day time frame, the current PCO agency must inform the consumer that a break in services will occur until the consumer selects an agency. The discharging agency may not ask the medicaid's designee to terminate the consumer's PCO services.

(3) A consumer has a right to appeal the agency's decision to suspend services as outlined in 8.352.2 NMAC, *Recipient Hearings*. A recipient has 90 days from the date of the suspension notice to request a fair hearing.

B. **Discharge by the state:** Medicaid or its designee reserves the right to exercise its authority to discontinue the consumer's receipt of PCO services due to the consumer's non-compliance with medicaid regulations and PCO service requirements. The consumer's discontinuation of PCO services does not affect his/her medicaid eligibility. The consumer may be discharged for a justifiable reason by means of a 30-day written notice to the consumer. The notice will include duration of discharge, which may be permanent, the consumer's right to request a fair hearing, pursuant to 8.352.2 NMAC, *Recipient Hearings*, and the justifiable reason for the decision to discharge. A justifiable reason for discharge may include:

(1) staffing problems (i.e., unjustified excessive requests for change in attendants three or more in a 30-day period), excessive requests for transfers to other agencies or excessive agency discharges;

(2) a consumer who demonstrates a pattern of verbal or physical abuse toward attendants, agency personnel, or state staff or contractors, including use of vulgar or explicit (i.e. sexually) language, verbal or sexual harassment, excessive use of force, demonstrates intimidating behavior, verbal or physical threats toward attendants, agency personnel, or state staff or contractors;

(3) a consumer or family member who demonstrates a pattern of uncooperative behavior including, not complying with agency, medicaid program requirements or regulations or procedures;

(4) illegal use of narcotics or alcohol abuse; and

(5) fraudulent submission of timesheets; or

(6) unsafe or unhealthy living conditions or environment.

C. PCO agencies, the TPA, and the MCO for CoLTS are all responsible for properly documenting and reporting any incidents involving a consumer that is described in Section B one through six above to medicaid or its designee.

[8.315.4.23 NMAC - Rp, 8.315.4.20 & 21 NMAC, 12-30-10; A, 9-15-11]

8.315.4.24 REIMBURSEMENT: A medicaid-approved PCO agency will process billings in accordance with the following.

A. Agencies must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, agencies receive instructions on documentation, billing, and claims processing. Claims must be filed per the billing instructions in the medicaid manual for FFS or instructions from the CoLTS MCO. PCO agencies must use ICD-9-CM diagnosis codes when billing for medicaid services.

B. Reimbursement for PCO services is made at the lesser of the following:

(1) the provider's billed charge;

(2) the medicaid fee schedule for the specific service or procedure; or

(3) the agency's billed charge must be its usual and customary charge for services.

(4) "usual and customary charge" refers to the amount an individual provider charges the general public in the majority of cases for a specific service and level of service.
[8.315.4.22 NMAC - Rp, 8.315.4.22 NMAC, 12-30-10]

8.315.4.25 PCO PROVIDER VOLUNTARY DISENROLLMENT: A medicaid approved PCO agency may choose to discontinue provision of services. Once approved by medicaid or its designee, the PCO agency may initiate the disenrollment process to assist consumers to transfer to another medicaid approved PCO agency. The PCO agency must continue to provide services until consumers have completed the transfer process and the agency has received approval from medicaid or its designee to discontinue services. Prior to disenrollment, the PCO agency must send a notice to medicaid or its designee for approval. The notice must include:

A. consumer notification letter;

B. list of all the medicaid approved personal care agencies serving the county in which the consumer resides; and

C. list of all consumers currently being served by the agency and the MCO in which they are enrolled.

[8.315.4.25 NMAC - Rp, 8.315.4.23 NMAC, 12-30-10]

8.315.4.26 SOLICITATION/ADVERTISING: For the purposes of this section, solicitation shall be defined as any communication regarding PCO services from an agency's employees, affiliated providers, agents or contractors to a medicaid recipient who is not a current client that can reasonably be interpreted as intended to influence the recipient to become a client of that entity. Individualized personal solicitation of existing or potential consumers by an agency for their business is strictly prohibited.

A. Prohibited solicitation includes, but is not limited to, the following:

(1) contacting a consumer who is receiving services through another PCO service or any another medicaid program;

(2) contacting a potential consumer to discuss the benefits of its agency, including door to door, telephone and email solicitation;

(3) offering a consumer/attendant a finder fee, kick back, or bribe consisting of anything of value to the consumer to obtain transfers to its agency; see 8.351.2 NMAC, *Sanctions and Remedies;*

(4) directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing activities by the entity's employees, affiliated providers, agents or contractors;

(5) making false promises;

(6) misinterpretation or misrepresentation of medicaid rules, regulations or eligibility;

(7) misrepresenting itself as having affiliation with another entity; and

(8) distributing PCO related marketing materials.

B. Penalties for engaging in solicitation prohibitions: Agencies found to be conducting such activity will be subject to sanctions and remedies as provided in 8.351.2 NMAC and applicable provisions of the PPA.

C. An agency wishing to advertise for PCO service provision, or its agency must first get prior written approval from medicaid or its designee before conducting any such activity. Advertising and community outreach materials means materials that are produced in any medium, on behalf of a PCO agency and can reasonably be interpreted as advertising to potential clients. Only approved advertising materials may be used to conduct any type of community outreach. Advertising or community outreach materials must not misrepresent the agency as having affiliation with another entity or use proprietary titles, such as "medicaid PCO". Any PCO agency conducting any such activity without prior written approval from medicaid or its designee will be subject to sanctions and remedies as provided in 8.351.2 NMAC and applicable provisions of the PPA.
[8.315.4.26 NMAC - Rp, 8.315.4.24 NMAC, 12-30-10

8.315.4.27 SANCTIONS AND REMEDIES: Any agency or contractor that is not compliant with the applicable medicaid regulations is subject to sanctions and remedies as provided in 8.351.2 NMAC.
[8.315.4.27 NMAC - N, 12-30-10]

HISTORY OF 8.315.4 NMAC:

History of Repealed Material:
8 .NMAC 4.MAD 738, Personal Care Services, filed 8-18-99 - Repealed effective 7-1-2004.
8.315.4 NMAC, Personal Care Option Services, filed 6-16-2004 - Repealed effective 9-15-2010.

8.315.4 NMAC, Personal Care Option Services, filed 8-20-2010 - Repealed effective 12-30-10

Personal Care Options Service Guide

8.315.4 NMAC Attachment-I

Name (First, Last)	**Case Number**	**Assessment Type** ☐ Initial ☐ Interim ☐ Annual	**Assessment/Discussion Date**
Paid Caregiver Relative? ☐ Yes ☐ No	**Lives with Paid Caregiver?** ☐ Yes ☐ No	**Shared PCO House?** ☐ Yes ☐ No	**Member Asks for More Task Time?** ☐ Yes ☐ No	**Assessor Name** (First, Last)

1. Hygiene/Grooming (daily)

	M - Minor Needs Level	S - Severe Needs Level	T - Total Needs Level
Bathing	**0 – 15 min**	**16 – 30 min**	**31 – 60 min**
Dressing	**0 – 10 min**	**11 – 15 min**	**16 – 20 min**
Grooming	**0 – 10 min**	**11 – 15 min**	**16 – 20 min**

- ☐ Lay out supplies
- ☐ Lay out clothing
- ☐ Draw water
- ☐ In/out of tub/shower
- ☐ Standby safety
- ☐ Zip, button, sock/shoe
- ☐ Comb/brush hair
- ☐ Rx skin care – <3/day
- ☐ Prompting/cueing
- ☐ Mobility

- ☐ Transfer from bed
- ☐ Tub bath/dry
- ☐ Sponge bath/dry
- ☐ In/out of clothes
- ☐ Brush Teeth
- ☐ Wash hands/face
- ☐ Shave face
- ☐ Shave legs/underarms
- ☐ Wash Hair
- ☐ Dry Hair
- ☐ Set/roll/braid hair
- ☐ Nail care
- ☐ Makeup
- ☐ Non Rx skin care
- ☐ Rx skin care – 3/day+
- ☐ Prompting/cueing
- ☐ Mobility

- ☐ Total help

Notes:
(2) Exclude assistance with Rx skin care for persons unable to self administer.

Needs Level: Bath:____ Dress:____ Groom:____
Other Supports: ☐ Yes ☐ No If yes, # of days/wk: ___

Min/Day: ____
Days/Wk: ____

2. Individual Bowel and Bladder (daily)

M - Minor Needs Level	S - Severe Needs Level	T - Total Needs Level
0 – 10 min	**11 – 20 min**	**21 – 40 min**

- ☐ Prepare supplies
- ☐ Clothing help
- ☐ Cleaning self help
- ☐ Standby help
- ☐ Prompting/cueing
- ☐ Mobility

- ☐ On/off bedpan
- ☐ Urinal help
- ☐ Toileting hygiene
- ☐ Feminine hygiene
- ☐ Change diapers
- ☐ Empty cath bag
- ☐ Colostomy bag chg
- ☐ External cath chg
- ☐ Prompting/cueing
- ☐ Mobility

- ☐ Total help

Note: Except for perineal care and toileting, a consumer must be medically stable and able to communicate and assess his/her own needs.

Needs Level: Individual Bowel and Bladder: ____
Other Supports: ☐ Yes ☐ No If yes, # of days/wk: ___

Min/Day: ____
Days/Wk: ____

3. Meal Preparation and Assistance (daily)

M - Minor Needs Level	S - Severe Needs Level	T - Total Needs Level
0 – 15 min	**16 – 30 min**	**31 – 45 min**

- ☐ Meal Planning
- ☐ Help preparing meals
- ☐ Warm, Cut and serve
- ☐ Prompting/cueing
- ☐ Mobility

- ☐ Cook full meal(s)
- ☐ Grind/puree food
- ☐ Prompting/cueing
- ☐ Mobility

Note: Shared PCO - 30 min. max or 45 with special needs

- ☐ Total help

Needs Level: Meal Preparation and Assistance: ____
Other Supports: ☐ Yes ☐ No If yes, # of days/wk: ___

Min/Day: ____
Days/Wk: ____

4. Eating (daily)

	M - Minor Needs Level	S - Severe Needs Level	T - Total Needs Level
Breakfast ☐	**0 – 5 min**	**6 – 15 min**	**16 – 30 min**
Lunch ☐	**0 – 5 min**	**6 – 15 min**	**16 – 30 min**
Dinner ☐	**0 – 5 min**	**6 – 15 min**	**16 – 30 min**

- ☐ Standby help
- ☐ Prompting/cueing
- ☐ Mobility

- ☐ Spoon feed
- ☐ Bottle feed
- ☐ Placing feed devices
- ☐ Prompting/cueing
- ☐ Mobility

- ☐ Total help

Needs Level: Eating: ____
Other Supports: ☐ Yes ☐ No If yes, # of days/wk: ___

Min/Day: ____
Days/Wk: ____

5. Household and Support Services (weekly)

	M - Minor Needs Level	S - Severe Needs Level	T - Total Needs Level
Cleaning	**0 – 45 min**	**46 – 90 min**	**91 – 110 min**
Laundry	**0 – 45 min**	**46 – 90 min**	**91 – 110 min**
Support	**0 – 15 min**	**16 – 30 min**	**31 – 40 min**

- ☐ Light cleaning
- ☐ Make bed
- ☐ Pick up after tasks
- ☐ Light laundry
- ☐ Light hand washing
- ☐ Gather/sort laundry
- ☐ Make shopping list
- ☐ Few shopping items
- ☐ Service Animal feed
- ☐ Prompting/cueing
- ☐ Mobility

- ☐ Dusting
- ☐ Living area(s)
- ☐ Bathroom
- ☐ Kitchen
- ☐ Refrigerator
- ☐ Change linens
- ☐ Clean bed-side toilet
- ☐ Carry out trash
- ☐ Load washer
- ☐ Load dryer
- ☐ Fold/put away laundry
- ☐ Assistive devices
- ☐ Shop for food
- ☐ Shop for clothes
- ☐ Errands/pick up meds
- ☐ Self-admin meds
- ☐ Prompting/cueing
- ☐ Mobility

- ☐ Total help

Notes:
(1) For any rating, add actual travel time, as appropriate.
(2) For any rating, exclude assistance with medications for persons unable to self administer.
(3) For any rating, assess jointly in shared living spaces and individually for special needs to include independent living spaces.

Needs Level: Clean:____ Laundry:____ Support:____
Other Supports: ☐ Yes ☐ No If yes, # of days/wk: ___

Min/Wk: ____

6. Supportive Mobility Assistance (daily)

M - Minor Needs Level	S - Severe Needs Level	T - Total Needs Level
0 – 15 min	**16 – 30 min**	**31 – 40 min**

- ☐ Some ambulation
- ☐ Some transferring
- ☐ Some repositioning
- ☐ Prompting/cueing

- ☐ Much ambulation
- ☐ Much transferring
- ☐ Much repositioning
- ☐ Prompting/cueing

- ☐ Total help

Note: This service is limited to individuals that require additional mobility assistance that is not covered with other PCO services. The functional level may be rated based on availability and use of appropriate adaptive devices.

Needs Level: Supportive Mobility Assistance: ____
Other Supports: ☐ Yes ☐ No If yes, # of days/wk: ___

Min/Day: ____
Days/Wk: ____

Summary of Weekly PCO Service Time

PCO Tasks	Wkly *Minutes*
1. Hygiene/Grooming	
2. Individual Bowel and Bladder	
3. Meal Preparation and Assistance	
4. Eating	
5. Household and Support Services	
6. Supportive Mobility Assistance	
Add up to 45 min/day if **hauling/heating water** is required →	
Total Weekly PCO *Hours*:	