

8 AGENCY BASED COMMUNITY BENEFIT

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Effective Date January 1, 2014

GENERAL INFORMATION

Members selecting the Agency-Based model have the choice of the consumer delegated or consumer directed models for personal care services.

DEFINITIONS

1. **Adult:** Individuals who are twenty-one (21) years of age or older.
2. **Allocation:** Funding becomes available to serve additional individuals on the 1115 waiver who are not otherwise Medicaid eligible.
3. **Annual:** The 12-month period covered by a Care Plan, except where otherwise stated.
4. **APS:** Adult Protective Services Division of the Aging and Long-Term Services Department.
5. **Care Coordinator or CC:** The individual responsible for coordinating services with members in the managed care program.
6. **Child:** An individual under twenty-one (21) years of age.
7. **Clinical Necessity:** Health care services that a healthcare Provider, exercising (a) clinical decisions made on behalf of an individual in a manner which result in the rendering of necessary, safe, effective, appropriate clinical services; (b) clinical decisions that result in the appropriate clinical intervention considering the severity and complexity of symptoms; (c) decisions that result in the rendering of clinical interventions consistent with the diagnosis and are appropriate for the member's response to the clinical intervention; (d) decisions rendered in accordance with the provider's professional scope of license or scope of practice regulations and statutes in the state where the provider practices.
8. **Community Re-integration:** Provides individuals the opportunity to move out of a skilled nursing facility after a 90 continuous day stay, back into the community.
9. **CYFD:** Children Youth and Family Department.
10. **Face -to - Face:** Being in the physical presence of the individual who is receiving services.
11. **Freedom of Choice:** A form that provides the member opportunities to select their choice for delivery of services as identified on the Care Plan.
12. **Health Care Plan:** A procedural plan that describes the provision of specified activities and oversight on a routine basis in order to safeguard the health of the individual. The Health Care Plan is developed and monitored by a nurse.
13. **HSD:** New Mexico Human Services Department.
14. **IDT:** Interdisciplinary Team, consisting of the member, the legally authorized representative, the family, service providers and other people invited by the member and the legal authority representative, if applicable.

15. **Immediate Family Member:** Father (includes natural or adoptive father, father-in-law, stepparent), mother (includes natural or adoptive mother, mother-in-law, stepparent), brother (includes half-brother, step-brother), sister (includes half-sister, step-sister), son or daughter, step-son or step daughter, adoptive son or daughter, natural grandfather, and natural grandmother and spouse relationship to the individual.
16. **Incident Report (IR):** Required form for documenting all reportable incidents of abuse, neglect, exploitation, death, expected and unexpected, environmental hazard, law enforcement intervention and emergency services.
17. **ISD:** Income Support Division, New Mexico Human Service Department.
18. **Level of Care or LOC:** Level of Care, an instrument used in determining the level of care (medical eligibility) for Community Benefit Services and for institutional care.
19. **LTCMA:** Long-Term Care Medical Assessment (ISD 379).
20. **MAD:** The Medical Assistance Division, New Mexico Human Services Department.
21. **Natural Family Member:** A person related by blood or adoption to include: mother, father, brother, sister, aunt, uncle, grandmother, grandfather, son, or daughter.
22. **Natural Home:** Residence of the individual or the primary caregiver.
23. **Natural Supports:** Supports not paid for with Medicaid funds that assist the individual to attain the goals as identified on the Care Plan. Individuals who provide natural supports are not paid staff members of a service provider, but they may be planned, facilitated, or coordinated in partnership with a provider.
24. **Non-Medical Health Care:** Promotion of or assistance with minor health needs; e.g. with minor cuts and scrapes, using menstrual supplies, or hygiene to promote health (e.g. denture cleaning).
25. **Parent:** Natural or adoptive mother or father, or stepmother, stepfather.
26. **Plan of Care:** A procedural plan that describes the provision of specified activities and oversight on a routine basis in order to safeguard the health of the individual. Form SCMS-485.
27. **Primary Caregiver:** Parent or surrogate parent providing day-to-day care of an individual.
28. **Relatives:** Immediate family members such as the parent of an adult, a sibling, grandparent, aunt, uncle, etc. but not the parent of a minor child or a spouse.
29. **Support:** Assistance to an individual that may or may not include a paid service.

AGENCY BASED COMMUNITY SERVICE STANDARDS

These standards apply to the services provided through the Medicaid 1115 Waiver for individuals who meet the eligibility criteria for [Home and Community-Based Services \(HCBS\)](#), Agency Based Community Benefit Services (ABCB). These standards clarify, interpret, and further enforce 8.308.12 NMAC, *Managed Care Program, Community Benefit*, effective January 1, 2014.

The standards address each service covered by the ABCB. Individuals served through this program will expect to receive services that meet these standards. [Centennial Care MCOs must contract with eligible ABCB providers before rendering Community Benefits to members. Eligible ABCB providers are those that have been approved and certified by the HSD/MAD Long Term Care provider enrollment unit, per 8.308.2.9 NMAC Managed Care Program, Provider Network, effective January 1, 2014.](#)

These standards define the services offered as approved by the Centers of Medicare & Medicaid (CMS). The ABCB services are a supplement to the member's natural supports and are not intended to replace family support. The ABCB is not a twenty-four (24) hour service. The services are designed to increase independence and achieve personal goals while providing care and support to enable individuals to live as active members of the community while ensuring health and safety. The purpose of this program is to provide assistance to individuals that require long-term supports and services so they may remain in the family residence, in their own home or in community residences. This program serves as an alternative to a Nursing Facility (NF). The ABCB services are implemented in accordance with the person-centered Care Plan as developed with the member and the MCO Care Coordinator (CC). The person-centered Care Plan must revolve around the individual ABCB member and reflect his/her chosen lifestyle, cultural, functional, and social needs for successful community living.

Home and Community-Based settings shall meet the following standards:

- i. are integrated and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;
- ii. are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and document in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;
- iii. ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- iv. optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
- v. facilitates individual choice regarding services and supports, and who provides them.

ABCB COVERED SERVICES

Adult Day Health Services ADULT DAY HEALTH SERVICES

Adult Day Health Services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of ABCB service members as determined by the Plan of Care incorporated into the Care Plan. Adult Day Health settings must be integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. The services are generally provided for two (2) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, by a licensed adult daycare, community based facility that offers health and social services to assist participants to achieve optimal functioning. Private Duty Nursing services and Skilled Maintenance Therapies (physical, occupational and speech) may be provided in conjunction with Adult Day Health services, but the Adult Day Health provider or by another provider. Private duty nursing and therapy services must be provided by licensed nurses

and therapists. The Private Duty Nursing and Skilled Maintenance Therapies must be provided in a private setting at the facility. Meals provided as part of this service shall not constitute a “full nutritional regime” (3 meals per day). Transportation to and from the Adult Day Health Center must be coordinated by the Adult Day Health program.

1. SCOPE OF SERVICES

- A. The health, safety and welfare of the member must be the primary concern of all activities and services provided. Program staff must supervise all activities. Specific services may include the following:
 - a. Coordination of transportation to and from the Adult Day Health center.
 - b. Activities that promote personal growth.
 - c. Activities that enhance the member’s self-esteem by providing opportunities to learn new skills and adaptive behaviors.
 - d. Supervision of self-administrated medication as determined by the New Mexico Nurse Practice Act.
 - e. Activities that improve capacity for independent functioning.
 - f. Activities that provide for group interaction in social and instructional programs and therapeutic activities.
 - g. Personal care services.
 - h. Meals that do not constitute a “full nutritional regime” of three (3) meals per day.
 - i. Intergenerational experiences.
 - j. Involvement in the greater community.
 - k. Providing access to community resources as needed.
- B. Activities shall be planned by the member, family, caregivers, volunteers, staff and other interested individuals and groups.
- C. The provider must assure safe and healthy conditions for activities inside or outside the facility.
- D. An interdisciplinary team meeting for each member will occur at least quarterly to review ongoing progress of direct services and activities. The Plan of Care will be adjusted as necessary to meet the needs of the member at the quarterly meeting or at other times as needed.
- E. A Plan of Care will be developed with identified goals and measurable objectives. It will be attached to or incorporated in the Care Plan.
- F. All activities must be supervised by program staff.
- G. Members must never be left unattended. An Adult Day Health center staff member must be physically present with the member(s) at all times.
- H. Activities must be designed to meet the needs of the member and enhance the member’s self-esteem by providing opportunities to:
 - a. Learn new skills and adaptive behaviors.
 - b. Improve or maintain the capacity for independent functioning.
 - c. Provide for group interaction in social and instruction programs and therapeutic activities.

2. AGENCY PROVIDER REQUIREMENTS

- A. Adult day health services may be provided by eligible adult day health agencies.
- B. Adult day health facilities must be licensed by Department of Health (DOH) as an adult day care facility pursuant to 7 NMAC 13.2.

- C. Adult day health facilities must meet all requirements and regulations set forth by DOH as an adult day care facility pursuant to 7 NMAC 13.2.
- D. Adult Day Health Centers must comply with the provisions of Title II and III of the American's with Disabilities Act (ADA) of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.).
- E. Adult Day Health Centers must comply with all applicable cities, county or state regulations governing transportation services.
- F. Must comply to the Human Services Department, Medical Assistance Division (HSD/MAD) requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background check, Labor Laws, etc. In order to be approved and certified by the HSD/MAD Long Term Care provider enrollment unit, Adult Day Health Centers must be operating with a fully approved permanent license. Incomplete applications to the HSD/MAD Long Term Care provider enrollment unit shall be rejected and not considered for review until a complete application is submitted.
- G. Adult Day Health Centers must make appropriate provisions to meet the needs of adults who require special services as indicated in the member's Care Plans.
- H. The MCO will provide a copy of the Care Plan to the Adult Day Health Services Provider.
- I. A written Adult Day Health Services Plan of Care (POC) will include the assessment of the special needs, the interventions to meet those needs, evaluation of the plan, with changes as needed. The POC will be provided to the MCO Care Coordinator and must be incorporated into the member's Care Plan.
- J. The provider must be culturally sensitive to the needs and preferences of the member. Communicating in a language other than English may be required.

3. REIMBURSEMENT

Billing is on an hourly basis and is accrued to the nearest quarter of an hour. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable. Reimbursement for adult day health services will be based on the negotiated rate with the MCO. Providers of service have the responsibility to review the prior authorizations issued from the MCO to assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS OR EXCLUSIONS

A minimum of two (2) hours per day for one (1) or more days per week.

Assisted Living **ASSISTED LIVING**

Assisted living is a residential service that provides a homelike environment which may be in a group setting, with individualized services designed to respond to the individual needs as identified by the Care Coordinator and the recipient of service, and incorporated in the Care Plan. Assisted living services include activities of daily living (i.e. ability to perform tasks that are essential for self-care, such as bathing, feeding oneself, dressing, toileting, and transferring) and instrumental activities of daily living (i.e. ability to care for household and social tasks to meet individual needs within the community).

Assisted living is based on the following fundamental principles of practice:

- Offering quality care that is personalized for the member's needs.
- Fostering independence for each member.

- Treating each member with dignity and respect.
- Promoting the individuality of each member.
- Allowing each member choice in care and life style.
- Protecting each member's right to privacy.
- Nurturing the spirit of each member.
- Involving family and friends in care planning and implementation.
- Providing a safe residential environment.
- Providing safe community outings or activities.

1. SCOPE OF SERVICES

A. Core services provide assistance to the member in meeting a broad range of activities of daily living. Specific services may include the following:

- a. Personal Hygiene.
- b. Dressing.
- c. Eating.
- d. Socialization.
- e. Opportunities for individual and group interaction.
- f. Housekeeping.
- g. Laundry.
- h. Transportation.
- i. Meal preparation and dining.
- j. Twenty-four (24) hour, on-site response capability to meet scheduled or unpredictable participant needs.
- k. Capacity to provide on-going supervision of the ABCB member within a twenty-four (24) hour period.
- l. Coordination of access to services not provided directly.
- m. Participation in the Interdisciplinary Team meetings for development of the Care Plan.
- n. Implementation of the plan to meet the needs, evaluation for effectiveness, and adaptation as needs change.
- o. Services provided to a resident of an Assisted Living program are pursuant to the Care Plan, developed by the recipient of services and the MCO care coordinator.
- p. Direct services provide assistance to the member in meeting a broad range of activities of daily living. Direct service provision may be provided by the Assisted Living Facility or may be provided by another approved provider. The direct care providers must be identified on the member's Care Plan and the Assisted Living Plan of Care, that is separate from the CP, and might include:
 1. Private Duty Nursing services for Adults (see the ABCB Service Standards for Private Duty Nursing).
 2. Skilled Maintenance Therapies for Adults (see the ABCB Service Standards for Skilled Maintenance Therapies).
 3. The cost of room and board is not a covered service in Assisted Living.

2. PROVIDER QUALIFICATIONS

- A. Assisted Living Services must be provided in the following facilities or environmental settings: Adult Residential Care Facilities – licensed by Licensing and Certification Bureau, Division of Health Improvement/Department of Health. Adult Residential Care Facilities must meet all requirements set forth by the Licensing and Certification Bureau Department of Health. This would include the definition of a “home-like” and the environment found in Section III of this document.
- ~~B.~~ Provider agencies must meet the minimum, applicable qualifications set forth by the Licensing and Certification Bureau of the Department of Health and HSD/MAD, including but not limited to: Labor Laws and Regulations, Criminal Background Checks, Employ Abuse Registry, Incident Management reporting, OSHA training requirements, etc. In order to be approved and certified by the HSD/MAD Long Term Care provider enrollment unit, Assisted Living facilities must be operating with a fully-approved permanent license.
- ~~C.~~ Provider agencies must comply with the provisions of Title II and III of the American’s with Disabilities Act (ADA) of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.).
- ~~D.~~ Provider agencies must comply with ensuring personnel providing direct services meet all certification standards established by HSD/MAD for personal services, private duty nursing and skilled maintenance therapies (see ABCB Service standards for each separate service especially the qualifications required i.e. nursing requires a license etc.).
- ~~E.~~ Providers of Assisted Living are required to maintain staffing ratios and patterns that will meet the individual members’ needs as identified in the Care Plans and the agency’s Plan of Care.
- ~~F.~~ The Assisted Living program will develop a Plan of Care for each member based on the assessment of the needs of the member, and include strategies to meet those needs. The Plans of Care must be evaluated for effectiveness, and revised as the needs of the members change. The Plan of Care is separate and incorporated into the Care Plan.
- ~~G.~~ The Assisted Living provider will develop a written agreement with each ABCB member residing in their assisted living facility. This agreement will detail all aspects of care to be provided including identified risk factors. Members shall be afforded receive the same responsibilities/protections from eviction as all tenants under landlord law of state, county, city or other designated entity. It will also include the financial agreement regarding the cost of room and board and the funding sources. A copy of this agreement and any later revisions must be forwarded to the MCO care coordinator. The original is maintained in the member’s file at the assisted living residence.
- ~~H.~~ Definition of “Home-Like” Environment: A “home-like” environment must possess the following structural features prior to the placement of the ABCB services recipient. Meeting these requirements is the financial responsibility of the Assisted Living Provider:
- a. A minimum of 220 square feet of living space, including kitchen space for newly constructed units. Rehabilitated units must provide a minimum of 160 square feet of living space.

- b. A minimum of 100 square feet of floor space in each single bedroom. Closet and locker areas shall not be counted as part of the available floor space. Members must have access to a separate common living area, kitchen and bathroom that are all accessible for persons with a disability.
- c. A minimum of 80 square feet of floor space per member in a semi-private bedroom (sharing a bedroom is the member's choice only). Closet and locker areas shall not be counted as part of the available floor space. Members must have access to a separate common living area, kitchen and bathroom that are all accessible for persons with a disability.
- d. Kitchens must be furnished with a sink, a refrigerator; at least a two burner stove top or 1.5 cubic foot microwave oven.
- e. Each unit must be equipped with an emergency response system.
- f. Common living areas must be smoke free.
- g. Floor plans must be submitted to the HSD/MAD along with the Medicaid Provider Participation Application or renewal.
- h. In addition CMS requires residential settings located in the community to provide members with the following:
 - 1. Private or semi-private bedrooms including decisions associated with sharing a bedroom: Full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas; All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs; Private or semi-private bathrooms that include provisions for privacy; Common living areas and shared common space for interaction between participants, their guests, and other residents; Members must have access to food storage or food pantry area at all times; Members must have the freedom and support to control their own schedules regarding ~~be provided with an opportunity to make decisions about~~ their day to day activities including having visitors of their own choosing at any time, when and what to eat, in their home and in the community; Members will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, have easy access to resources and activities of their choosing in the community.
 - 2. In provider owned or controlled residential settings, the following additional conditions will be provided to members: Privacy in sleeping or living unit; units have lockable entrance doors, with members and appropriate staff having keys to doors; Members share units only at the member's choice and have a choice of roommates in that setting; Members have freedom to furnish and decorate sleeping or living units as specified in the lease or agreement; The setting is physically accessible to the member.

3. Any modification of the above conditions must be supported by a specific ~~assessed~~ need and justified and documented in the Plan of Care to address the following:
 - a. identify a specific and individualized assessed need;
 - b. document the positive interventions and supports used prior to any modifications to the Plan of Care;
 - c. document less intrusive methods of meeting the need that have been tried but did not work;
 - d. include a clear description of the condition that is directly proportionate to the specific assessed need;
 - e. include regular collection and review of data to measure the ongoing effectiveness of the modification;
 - f. include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
 - g. include the informed consent of the individual; and
 - ~~a~~-h. include an assurance that interventions and supports will cause no harm to the individual.

3. REIMBURSEMENT

The billable unit rate for Assisted Living services is based on a daily rate.

A. Room and Board

- a. The Agency Based Community Benefit does not reimburse for room and board costs for the member (such as rent, groceries, etc.).
- b. Room and board rates billed to the ABCB services must be reported to the HSD/MAD along with the Medicaid Provider Participation Agreement application and renewal prior to the provision of assisted living services by the provider agency. Any subsequent changes to those rates must also be forwarded to the HSD/MAD when they occur.
- c. The provider agency must comply with all state and federal guidelines regarding the establishment of room and board rates to the ABCB services recipients.
- d. Training on member specific issues is reimbursable.

B. Non Billable Activities

- a. The Assisted Living Services provider will not bill MCO for Room and Board.
- b. General training requirements are an administrative cost and not billable.
- c. The Provider will not bill when an individual is hospitalized or in an institutional care setting.

2. LIMITS OR EXCLUSIONS

Assisted Living services will not include the following ABCB services: Personal care, Respite, Environmental Modifications, Emergency Response or Adult Day Health. This is because the Assisted Living Program is responsible for all of these services at the Assisted Living facility. Therefore provision of these services in addition to the Assisted Living would constitute duplication of services.

BEHAVIOR SUPPORT CONSULTATION

A Behavior Support Consultant (BSC) is a licensed professional as specified by applicable State laws and standards. Behavior support consultation services assist the participant with a developmental disability and his or her family as well as the direct support professionals (DSP). Behavior support consultation services for the participant include: assessments, evaluations, treatments, interventions, follow-up services and assistance with challenging behaviors and coping skill development. Services for the parents, family members and DSPs include training in dealing with challenging behaviors and assistance with coping skill development at home and in the community.

1. SCOPE OF SERVICES

- A. Behavior support consultation services are initiated when the MCO Care Coordinator identifies and recommends the service be provided to the member/member's representative. The Care Coordinator is responsible for including recommended units of behavior support consultation services. It is the responsibility of the participant/participant representative, and Care Coordinator, to assure units of therapy do not exceed the capped dollar amount determined for the participant/participant representative's Level of Care (LOC) and Care Plan cycle. Strategies, support plans, goals and outcomes will be developed based on the identified strengths, concerns and priorities in the Care Plan.
- B. Behavior Support Consultation Services Include:
 - a. Providing assessments, evaluations, development of treatment plans and interventions, training, monitoring of the participant/participant representative, and planning modification as needed for therapeutic purposes within the professional scope of practice of the BSC.
 - b. Designing, modifying and monitoring the use of related activities for the participant/participant representative that is supportive of the Care Plan.
 - c. Training families and DSPs in relevant settings as needed for successful implementation of therapeutic activities, strategies, and treatments.
 - d. Consulting with the Interdisciplinary Team (IDT) member(s), guardians, family, or support staff.
 - e. Consulting and collaborating with the participant/participant representative's primary care provider (PCP) and/or other therapists and/or medical personnel for the purposes of evaluation of the participant or developing, modifying or monitoring behavior support consultation services for the participant.
 - f. Observing the participant/participant representative in all relevant settings in order to monitor the participant's status as it relates to therapeutic goals or implementation of behavior support consultation services and professional recommendations.
 - g. Services may be provided in a clinic, home, or community setting.
- C. Comprehensive Assessment Guidelines:
 - a. The BSC must perform an initial comprehensive assessment for each participant to give the appropriate behavior support recommendations, taking into consideration the overall array of services received by the participant. A comprehensive assessment must be done at least annually and when clinically indicated.

- D. Attendance at the IDT Meeting:
- a. The BSC is responsible for attending and participating, either in person or by conference call in IDT meetings convened for service planning.
 - b. If unable to attend the IDT meeting, the BSC is expected in advance of the meeting to submit recommended updates to the strategies, support plans, and goals and objectives. The BSC and MCO Care Coordinator will follow up after the IDT meeting to update the BSC on specific issues.
 - c. The BSC must document in the participant's clinical file the date, time, and any changes to strategies, support plans, and goals and objectives as a result of the IDT meeting.
- E. Discharge Planning Documentation Includes:
- a. Reason for discontinuing services (such as failure to participate, request from participant/participant representative, goal completion, and/or failure to progress).
 - b. Written discharge plan shall be provided to the participant/participant representative and the MCO Care Coordinator by the BSC.
 - c. Strategies developed with participant/participant representative that can support the maintenance of behavioral support activities.
 - d. Family and direct support professional training that is completed in accordance with the written discharge plan.
 - e. Discharge summary is to be maintained in the clinical participant file maintained by the BSC and a copy is to be sent to the MCO Care Coordinator and distributed to the participant/participant representative.
- F. Agency/Individual Provider Requirements
- a. All BSCs who are working independently, or as employees of a provider agency who offer behavior support consultation services shall meet all the requirements of the ABCB Service Standards.
 - b. The agency must maintain a current provider status through the HSD/MAD Provider Enrollment Unit. Contact Provider Enrollment Unit for details.
- G. Agency/Individual Administrative Requirements
- a. BSC Requirements:
 1. Master's degree from an accredited school for psychology, social work, counseling or guidance program and maintain current license as required by New Mexico State Law.
 2. Acceptable licensure includes:
 - New Mexico Licensed Psychologist or Psychologist Associate.
 - New Mexico Licensed Independent Social Worker (LISW).
 - New Mexico Licensed Master Social Worker (LMSW).
 - New Mexico Licensed Clinical Counselor (LPCC).
 - New Mexico Licensed Marriage and Family Therapist (LMFT).
 3. Maintain a culturally sensitive attentiveness to the needs and preferences of participants and their families based upon culture

and language. Communicating in a language other than English may be required.

4. Licensed BSCs identified in Section III. A. of this document may provide billable behavior support consultation services.

H. Documentation:

- a. Documentation must be completed in accordance with applicable HSD/MAD and federal guidelines.
- b. All documents are identified by title of document, participant name, and date of documentation. Each entry will be signed with appropriate credential(s) and name of person making entry.
- c. Verified Electronic Signatures may be used. BSC name and credential(s) typed on a document is not acceptable.
- d. All documentation will be signed and dated by the BSC providing services.
- e. A copy of the annual evaluation and updated treatment plan will be provided to the MCO Care Coordinator within 10 business days following the IDT meeting. The treatment plan must include intervention strategies, as well as frequency and duration of care. The goals and objectives must be measurable.
- f. BSC progress/summary notes will include date of service, beginning/end time of service, location of service, description of service provided, participant/family/DSP response to service, and plan for future service.
- g. The summary will include the number and types of treatment provided and will describe the progress toward BSC goals using the parameters identified in the initial and annual treatment plan and/or evaluation.
- h. Any modifications that need to be included in the Care Plan must be coordinated with the MCO Care Coordinator.
- i. Complications that delay, interrupt, or extend the duration of the program will be documented in the participant's medical record and in communications to the Physician/Healthcare provider as indicated.
- j. Each participant will have an individual clinical file maintained by the provider.
- k. Review Physician/Healthcare provider orders at least annually and as appropriate, and recommend revisions on the basis of evaluative finding.
- l. Copies of BSC contact notes and BSC documentation may be requested by HSD/MAD for assurance purposes.

I. Reimbursement

Each provider of a service is responsible for providing clinical documentation that identifies the provider's role in all components of the provision of care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each member's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the Care Plan that is coordinated with the participant/participant representative and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and authorized by the

approved authorization. Payment for behavior support consultation services through the MCO is considered payment in full. Reimbursement for BSC services will be based on the negotiated rate. Service providers have the responsibility to review and assure that the information on the prior authorization for their services is current. If the provider identifies an error, they will contact the MCO immediately to have the error corrected. HSD/MAD does not consider the following to be professional BSC duties and will not authorize payment for:

- a. Performing specific errands for the participant/participant representative or family that is not program specific.
- b. Friendly visiting, meaning visits with the participant outside of work scheduled.
- c. Financial brokerage services, handling of participant finances or preparation of legal documents.
- d. Time spent on paperwork or travel that is administrative for the provider.
- e. Transportation of participant/participant representative.
- f. Pick up and/or delivery of commodities.
- g. Other non-Medicaid reimbursable activities.

J. ~~Community Reintegration~~

~~The individual participating in the community re-integration process must be capable of comprehending the decisions being made or have a primary caregiver or legal surrogate that understands the options. The individual must not require Agency Based Community Benefit (ABCB) services 24 hours per day in his/her home, on an ongoing basis; as the intent of this process is to assist the individual to become integrated into their community as independent as possible. MCO must be able to ensure a reasonable level of health and safety for the member while ABCB services are being provided. ABCB services provided to these individuals must be cost-effective. Services provided under the ABCB must not exceed the average annual per capita costs of Nursing Facility services. HSD/MAD can refuse ABCB services to individuals whose health and safety would be at risk in the community as deemed by the interdisciplinary team which would include the MCO, the primary care physician, service providers in conjunction with a technical assistance with HSD/MAD.~~

~~Community Re-integration Registration for the ABCB can be completed by calling the Aging and Disability Resource Center (ADRC). Once a 90 continuous day stay is confirmed by the HSD/MAD and funding is available, a community re-integration allocation is granted. The HSD/MAD sends the allocation packet to the registrant/representative. The allocation paperwork (Primary Freedom of Choice form PFOC) must be returned to the HSD/MAD within 45 calendar days or the allocation will be closed and the registrant would need to re-register and wait for another allocation. If an extension is needed, HSD/MAD must be notified to grant the extension.~~

~~Once the PFOC is received by the HSD/MAD, it is faxed to the local Income Support (ISD) office. It is also faxed to the MCO. Once the allocation has been granted,~~

~~the registrant may leave the nursing home if a safe and appropriate discharge is arranged.~~

~~The MCO must contact the registrant within 5 business days of receipt of the PFOC to schedule an initial assessment. The assessor explains the Community Reintegration process to the applicant/representative. If the registrant/representative wishes to remain in the institution, the Waiver Refusal Form must be completed, signed and faxed to HSD/MAD. If the registrant/representative wishes to proceed with the eligibility process, the MCO proceeds with the medical eligibility process.~~

~~Once medical and financial eligibility is approved, ABCB services will be initiated.~~

COMMUNITY TRANSITION SERVICES

Community Transition Services are non-recurring set-up expenses for adults 21 years old and older who are transitioning from a skilled nursing facility to a living arrangement in the community where the person is directly responsible for his or her own on-going living expenses.

This service is not intended to cover the household costs of the member's natural supports.

~~This service is not intended to establish the household of a member's natural supports.~~

Allowable expenses are those necessary to enable a member to establish a basic household. Community Transition Services are furnished only when the member is unable to meet the expenses to establish his/her household or when the services cannot be obtained from other sources. Community Transition Services may not be used to furnish or establish living arrangements owned or leased by a service provider, except an assisted living facility. Services must be reasonable and necessary as determined by the MCO and authorized in the Care Plan.

1. SCOPE OF SERVICES

Community transition services must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- A. Security deposits that are required to obtain a lease on an apartment or home. Monthly rental or mortgage expenses are not covered; therefore, the member should have sufficient resources to pay for the first month's rent or mortgage as well as ongoing rent or mortgage costs.
- B. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens.
- C. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water.
- D. Services necessary for the individual's health and safety such as but not limited to, pest eradication and one-time cleaning prior to occupancy.
- E. Moving expenses.
- F. Fees to obtain a copy of birth certificate, identification card or driver's license.

2. AGENCY PROVIDER REQUIREMENTS

The Community Transition Services may be provided directly by the MCO or contracted out to an outside Community Transition Agency (CTA). The CTA is defined as an agency that provides community transition services to individuals who are transitioning from a nursing facility to a home and community-based residence. The CTA must be able to provide at least two of the following core services:

- A. Information and referral.
- B. Independent living skills training.
- C. Peer counseling.
- D. Individual and systems advocacy.
- E. Community transition agencies include but are not limited to Centers for Independent Living and Area Agencies on Aging.

3. REIMBURSEMENT

Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

Reimbursement for community transition services will be based on the negotiated rate with the MCO. Providers of service have the responsibility to review the prior authorizations issued from the MCO to assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS OR EXCLUSIONS

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

Additional exclusions: music systems, cable/internet, TV, VCR, DVD, MP3 player, telephone equipment, computer, exercise equipment, personal hygiene items, decorative items, experimental or prohibited treatments and memberships.

Community Transition Services are limited to \$3,500.00 per person every five years. In order to be eligible for this service, the person must have a nursing facility stay of at least 90 days prior to transition to the community.

EMERGENCY RESPONSE SERVICES

Emergency Response Services are provided through an electronic monitoring system to secure help in the event of an emergency. This service is to be used by ABCB service recipients whose safety is at risk. The member may use a portable “help” button to allow for mobility in his/her home environment. The monitoring system has a twenty-four hour, seven day a week monitoring capability. The system is connected to the member’s phone and programmed to send a signal to a response center once the “help” button is activated. This response system helps ensure that the appropriate person(s) or service agency responds to alarm calls. Emergency Response Services are provided pursuant to the Care Plan.

1. SCOPE OF SERVICES

- A. Services provided by emergency response systems:

- a. Installation, testing and maintenance of equipment.
 - b. Training on the use of the equipment to members/caregivers and first responders.
 - c. 24-hour monitoring for alarms.
 - d. Monthly systems check, or more frequently if electrical outages, severe weather systems, etc. warrant more frequent checks.
 - e. Reports of member emergencies to the Care Coordinator and changes in the member's condition that may affect service delivery.
- B. The response center must be staffed by trained professionals.
 - C. Emergency response service categories consist of emergency response, emergency response high need.

2. AGENCY PROVIDER REQUIREMENTS

- A. Emergency Response Providers must comply with all laws, rules and regulations of the New Mexico state corporation commission for telecommunications and security systems, if applicable.
- B. Provider agencies must establish and maintain financial reporting and accounting for each member.
- C. Emergency Response Service Providers must provide the member with information regarding services rendered, limits of service, and information regarding agency service contracts. This information will also include whom to contact if a problem arises, liability for payment of damages over normal wear, and notification when change of service occurs.
- D. The agency will have security bonding.
- E. Emergency Response Service Providers must report emergencies and changes in the member's condition that may affect service delivery to the Care Coordinator within 24 hours.
- F. Emergency Response Service Providers must complete quarterly reports for each member served. The original report must be maintained in the member's file and a copy must be submitted to the MCO Care Coordinator.

3. REIMBURSEMENT

- A. Reimbursement for emergency response services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.
- B. A monthly fee charged for each calendar month of use ongoing through entirety of a contractual agreement.
- C. A fee for special equipment (e.g., is bracelet rather than a necklace) must be medically necessary and substantiated by the MCO. This is designated as Emergency Response – High Need.

4. LIMITS OR EXCLUSIONS

- A. Eligible members must have a landline phone.

EMPLOYMENT SUPPORTS

Employment Supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that an individual may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational and/or vocational assessments and profiles; education of the eligible member and co-workers on rights and responsibilities; and benefits counseling.

The service must be tied to a specific goal specified in the individual's Care Plan. Job development is a service provided to eligible members by skilled staff.

The service has five components: 1) job identification and development activities; 2) employer negotiations; 3) job restructuring; 4) job sampling; and 5) job placement.

Employment Supports will be provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by eligible members receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

1. SCOPE OF SERVICES

Supported employment facilitates competitive work in integrated work settings for individuals with disabilities (i.e. psychiatric, mental retardation, learning disabilities, and traumatic brain injury) for whom competitive employment has not traditionally occurred, and who, because of the nature and severity of their disability, need ongoing support services in order to perform their job. Employment Supports settings must be integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive provide access to services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Supported employment provides assistance such as job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision.

A. Basic Components

Supported employment services should achieve the following outcomes: opportunity to earn equitable wages and other employment-related benefits, development of new skills, increased community participation, enhanced self-esteem, increased consumer empowerment, and quality of life. The types of supported employment services used depend on the needs of individual consumers. The following are the basic components of supported employment:

- a. Paid Employment - Wages are a major outcome of supported employment. Work performed must be compensated with the same benefits and wages as other workers in similar jobs receive. This includes sick leave, vacation time, health benefits, bonuses, training opportunities, and other benefits.
- b. Integrated Work Sites - Integration is one of the essential features of employment supports. Members with disabilities should have the same opportunities to participate in all activities in which other employees

participate and to work alongside other employees who do not have disabilities.

Members who are interested in pursuing work should discuss this with their MCO Care Coordinator and assure it is a goal within their plan. They should then be referred to Vocational Rehabilitation. No persons should request employment supports services through the ABCB program without utilizing the services of Vocational Rehabilitation Services. It is V.R.'s role to work with the person to develop an employment plan, assess abilities, and determine whether long term support is needed.

Employment Supports does not include sheltered work or other similar types of vocational services furnished in specialized facilities (federal guidelines). The employment setting needs to be in an integrated setting.

Members are still eligible for accessing Community Services in conjunction with Employment Supports.

2. AGENCY PROVIDER REQUIREMENTS

- A. Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the HSD/MAD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.
- B. The Provider Agency shall maintain a confidential case file for each individual and will include the following items:
 - a. Quarterly progress reports.
 - b. Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or HSD/MAD.
 - c. Career development plan as incorporated in the Care Plan; a career development plan consists of the vocational assessment and the Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability.
- C. PROVIDER AGENCY REPORTING REQUIREMENTS:
 - a. The Supported Employment Provider Agency shall submit the following to the MCO Care Coordinator:
 - b. Quarterly Progress Reports based upon the individual's Care Plan cycle;
 - c. Vocational Assessment; and

- d. Written updates, at least every six (6) months, to the Work/Learn Action Plan.
- D. Training Requirements: Each Provider Agency shall retain staff trained to establish Career Development Plans. Training will be provided by the Provider Agency necessary to ensure that individuals are able to demonstrate competency in skills listed under these standards.
- E. Staffing Requirements (Individual to Staff Ratio):
 - a. The provider shall ensure adequate staffing to assure health, safety, and promote positive work behavior and growth. The amount of staff contact time shall be adequate to meet the individual's needs and outcomes as indicated in the Care Plan and may vary according to purpose (e.g., job development, job training, job stabilization, career enhancement). For Individual Supported Employment, the staff to individual ratio is 1:1 unless otherwise specified in the Care Plan. For Individual Supported Employment, a minimum of 1 one-hour face-to face visit per month is required.
 - b. Staffing Restrictions: Agencies may not employ or sub-contract direct care personnel who are an immediate family member or who are a spouse of the individual served to work in the setting in which the individual is served.
 - c. Supervision: In a group employment setting, the provider determines the job site and is responsible for the day-to-day supervision of the individuals and for follow-up services. For individual placements, the employer is responsible for the provision of general supervision consistent with his or her role as employer. When necessary and appropriate, the Supported Employment Provider Agency may supplement these services.
- F. Qualification and Competencies for Employment Supports Staff: Qualifications and competencies for staff providing job coaching/consultation services shall, at a minimum, be able to:
 - a. Provide supports to the individual as contained in the Care Plan to achieve his or her outcomes and goals;
 - b. Employ job-coaching techniques and to help the individual learn to accomplish job tasks to the employer's specifications;
 - c. Increase the individual's capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;
 - d. Identify and strengthen natural supports that are available to the individual at the job site and fade paid supports in response to increased natural supports;
 - e. Identify specific information about the individual's interests, preferences and abilities;
 - f. Effectively communicate with the employer about how to support the individual to success including any special precautions and considerations of the individual's disability, medications, or other special concerns;
 - g. Monitor and evaluate the effectiveness of the service and provide documentation that this information is effectively communicated to the

MCO Care Coordinator and the IDT members through progress notes, quarterly reports, and participation in IDT meetings;

- h. Address behavioral, medical or other significant needs identified in the Care Plan that require intensive one-on-one staff support;
- i. Communicate effectively with the individual including communication through the use of adaptive equipment if applicable, at the work site;
- j. Document information that pertains to Care Plan, progress notes, outcomes, and health and safety issues/concerns and any and all other required documentation by HSD/MAD;
- k. Adhere to relevant state policies/standards and Provider Agency policies and procedures that directly impact services to the individual;
- l. Model behavior, instruct and monitor any work place requirements to the individual;
- m. Adhere to professionally acceptable business attire and appearance, and communicate through interactions a business-like, respectful manner; and
- n. Adherence to the rules of the specific work place, including dress, confidentiality, safety rules, and other areas required by the employer.

3. REIMBURSEMENT

Employment Supports provider agencies must maintain appropriate record keeping of services provided, personnel and training documentation, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursements for Employment Support services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS OR EXCLUSIONS

Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program. Federal financial participation cannot be claimed to defray expenses associated with starting up or operating a business.

ENVIRONMENTAL MODIFICATIONS

Environmental Modification services include the purchase and /or installation of equipment and or making physical adaptations to an eligible member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance the member's level of independence.

1. SCOPE OF SERVICES

Environmental Modifications are physical adaptations and environmental control systems excluding durable medical equipment. Environmental Modifications need to be identified in the member's Care Plan. Adaptations include the installation of ramps and hand rails; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, lowering counters, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated, and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

Environmental Modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects. These modifications shall exclude those adaptations, improvements or repairs to the existing home that do not directly affect accessibility. Environmental Modifications excludes such things as carpeting, roof repair, furnace replacement, remodeling bare rooms, and other general household repairs.

- A. *Duplicate Adaptations*: No duplicate adaptations, modifications or improvements shall be approved regardless of the payment source. For example, if the client has a safe and usable ramp, a replacement ramp shall not be approved.
- B. *New Construction*: This service cannot be used to fund apartment buildings and Assisted Living facilities.

2. AGENCY PROVIDER REQUIREMENTS

- A. The environmental modification provider must comply with all New Mexico state laws, rules and regulations, including applicable building codes.
- B. The environmental modification provider must have valid New Mexico regulation and licensing department, construction industries division GB02 class or higher construction license pursuant to the Construction Industries Licensing Act NMSA 1978, Section 60-13-3.
- C. The environmental modification provider must provide a (1) one-year warranty from the completion date on all parts and labor.
- D. The environmental modification provider must have a working knowledge of Environmental Modifications and be familiar with the needs of persons with functional limitations in relation to Environmental Modifications.
- E. The environmental modification provider must ensure proper design criteria as addressed in planning and design of the adaptation.

- F. The environmental modification provider must provide or secure licensed MCO(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects;
- G. The environmental modification provider must provide consultation to family members, waiver providers and MCOs concerning environmental modification projects to the individual's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.
- H. The environmental modification provider must establish and maintain financial reporting and accounting for each member.
 - a. The environmental modification provider will submit the following information and documentation to the MCO:
 1. Environmental modification evaluation;
 2. Service Cost Estimate. Photographs of the proposed modifications. The estimated start date of the work on the proposed modification; (equipment, materials, supplies, labor, travel, per diem, report writing time, and completion date of modification);
 3. Letter of Acceptance of Service Cost Estimate signed by the member;
 4. Letter of Permission from property owner. If the property owner is someone other than the member, the letter must be signed by the property owner and the member;
 5. The Construction Letter of Understanding. If the property owner is someone other than the member, the letter must be signed by the property owner and the member;
 6. Documentation demonstrating compliance with the Americans with Disabilities Act (ADA).
- I. The Provider must submit the following to the MCO, after the completion of work:
 - a. Letter of Approval of Work completed signed by the member; and
 - b. Photographs of the completed modifications.
- J. The MCO must submit the following information to the provider:
 - a. Care Coordinator Individual Assessment of Need.
- K. Note: ALTERNATIVES; The MCO shall first consider alternative methods of meeting the individual's needs, since the MCO is the payer of last resort. This would include insurance, workman's compensation, vocational rehabilitation, volunteer organizations, etc. The MCO must include documentation that all other viable resources to fund the proposed modification have been contacted and refused.

3. REIMBURSEMENT

Environmental Modification provider agencies must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on a project basis, One (1) unit per environmental modification project. Reimbursement for Environmental Modification services will be based on the negotiated rate with the MCOs. Providers of service have

the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS OR EXCLUSIONS

- A. Environmental modification services are limited to five thousand dollars (\$5,000.00) every five (5) years.
- B. Administrative Costs of the provider of the environmental modification services will not exceed fifteen percent (15%) of the total cost of the environmental modification project for each project managed by the MCO.

HOME HEALTH AIDE

Home Health Aide Services provide total care or assist an eligible member in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake.

1. SCOPE OF SERVICES

The Home Health Aide services assist the eligible member in a manner that promotes an improved quality of life and a safe environment for the eligible member. Home Health Aide services can be provided outside the eligible member's home. State Plan Home Health Aide services are intermittent and provided primarily on a short-term basis; whereas, Home Health Aide services are provided hourly, for eligible members who need this service on a more long term basis. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home Health Aides perform an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assisting with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records.

Home health aide services must be provided under the supervision of a registered nurse or other appropriate professional staff. The agency must make a supervisory visit to member's residence at least every two weeks to observe and determine whether goals are being met.

2. AGENCY PROVIDER REQUIREMENTS

- A. The Home Health Aide (HHA) Agency must be an approved provider with HSD/MAD.
- B. HHA Qualifications:
 - a. HHA Certificate from an approved community based program following the HHA training federal regulations 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or;
 - b. HHA training at the licensed Home Health Agency which follows the federal HHA training regulation in 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or;
 - c. A Certified Nurses' Assistant (CNA) who has successfully completed the employing HH Agency's written and practical competency standards and

- meets the qualifications for a HHA. Documentation will be maintained in personnel file.
- d. A HHA who was not trained at the employing HH Agency will need to successfully complete the employing HH Agency's written and practical competency standards before providing direct care services. Documentation will be maintained in personnel file.
 - e. The HHA will be supervised by the HH Agency RN supervisor or HH Agency RN designee at least once every two weeks in the member's home.
 - f. The HHA will be culturally sensitive to the needs and preferences of the participants and their families. Based upon the individual language needs or preferences, HHA may be requested to communicate in a language other than English.
- C. All supervisory visits/contacts must be documented in the member's Home Health Agency clinical file on a standardized form that reflects the following:
- a. Service received;
 - b. Member's status;
 - c. Contact with family members;
 - d. Review of HHA plan of care with appropriate modification annually and as needed.
- D. Requirements for the HH Agency Serving ABCB Population:
- a. The HH Agency nursing supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and HHA.
 - b. The HH Agency staff will be culturally sensitive to the needs and preferences of participants and households. Arrangement of written or spoken communication in another language may need to be considered.
 - c. The HH Agency will document and report any noncompliance with the Care Plan to the MCO Care Coordinator.
 - d. All Physician orders that change the member's service needs should be conveyed to the MCO Care Coordinator for coordination with service providers and modification to Care Plan if necessary.
 - e. The HH Agency will document in the member's clinical file that the RN supervision of the HHA occurs at least once every two weeks. Supervisory forms must be developed and implemented specifically for this task.
 - f. The HH Agency and MCO Care Coordinator must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care.
 - g. The HH Agency supervising RN, direct care RN and LPN shall train families, direct support professionals and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies or other areas of concern.
 - h. It is expected the HH Agency will consult with, Interdisciplinary Team (IDT) members, guardians, family, and direct support professionals (DSP) as needed.

3. REIMBURSEMENT

Home Health Aide provider agencies must maintain appropriate record keeping of services provided personnel and training documentation, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for home health aide services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

PERSONAL CARE SERVICES (PCS)

1. SCOPE OF SERVICES

PCS 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. This policy describes PCS for consumers who meet NF LOC because of disability or functional limitation and need assistance with certain ADLs and instrumental activities of daily living (IADLs).

- A. The MCO determines medical LOC for PCS eligibility upon initial application and at least annually thereafter. Medicaid-eligible individuals may contact the managed care organization (MCO) to apply for PCS.
- B. The goals of PCS are to avoid institutionalization and to maintain the consumer's functional level and independence. Although a consumer's assessment for the amount and types of services may vary, PCS are not provided 24 hours a day.
- C. PCS is a Medicaid service, not a Medicaid category of assistance, and services are delivered pursuant to an Individual Plan of Care (IPoC). PCS include a range of ADL and IADL services to consumers who meet NF LOC because of a disability or functional limitation(s). Consumers will be assessed for services at least annually, or more frequently, as appropriate. PCS will not include those services for a task the individual is already receiving from other sources such as tasks provided by natural supports. Natural supports are friends, family, and the community (through individuals, clubs and organizations) that are able and consistently available to provide supports and services to the consumer. The Comprehensive Needs Assessment (CNA) is conducted pursuant to the managed care service agreement. The CNA is performed by the MCO and determines the amount and type of services needed to supplement the services a consumer is already receiving including those services provided by natural supports. PCS must be related to the individual's functional level to perform ADLs and IADLs as indicated in the CNA.

2. ELIGIBLE POPULATION

To be eligible for Personal Care Services (PCS), a member must meet all of the following criteria:

- A. Be a recipient of a full benefit Medicaid category of assistance and, not be receiving other Medicaid HCBS waiver benefits, Medicaid Nursing Facility, Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)

Medicaid, PACE, or Adult Protective Services attendant care program, at the time PCS are furnished; an individual residing in a NF or ICF/IID Medicaid is eligible to apply for PCS to facilitate NF discharge; recipients of community transition goods or services may also receive PCS; all individuals must meet the Medicaid eligibility requirements to receive PCS; the MCO, Medicaid or its alternative designee must conduct an assessment (CNA) or evaluation to determine if the transfer to PCS is appropriate and if the PCS would be able to meet the needs of that individual;

- B. Be age 21 or older;
- C. Be determined to have met NF LOC by the MCO; and
- D. Comply with all Medicaid and PCS regulations and procedures.

3. LEVEL OF CARE (LOC) DETERMINATION

To be eligible for PCS, a consumer must meet the LOC required in a NF. The MCO makes initial LOC determination and subsequent determinations at least annually thereafter.

- A. The MCO approves the consumer's LOC for a maximum of one year (12 consecutive months); a new LOC determination must be made at least annually to ensure the consumer continues to meet medical eligibility criteria for PCS; each LOC determination must be based on the consumer's current medical condition and need of service(s), and may not be based on prior year LOC determinations; the approved NF LOC has a start date and an end date of no more than 12 consecutive months, which is the NF LOC span.
- B. Any individual applying for PCS who has an existing approved NF LOC determination in another program (i.e., nursing facility) will not need an additional LOC determination until his/her next annual assessment.
- C. A PCS agency that does not agree with the LOC determination made by the MCO or Medicaid's designee may work with the consumer's physician or physician designee to request a re-review or reconsideration from the MCO.
- D. A member that does not agree with the LOC determination made by the MCO may file a grievance or appeal with the MCO. The MCO grievance or appeal process must be exhausted before the consumer may request a fair hearing with HSD pursuant to 8.352.2 NMAC, Recipient Hearings.
- E. The MCO shall review the LOC determination upon a referral from the PCS agency, the consumer, or the consumer's legal representative when a change in the consumer's health condition is identified and make a new determination, if appropriate.

4. SERVICE DELIVERY MODELS

- A. Consumers eligible for PCS have the option of choosing the consumer-delegated or the consumer-directed personal care model. In both models, the consumer may select a family member (except the spouse), a friend, neighbor, or other person as the attendant. The MCO's care coordinator is responsible for explaining both models to each consumer, initially, and annually thereafter.
 - a. In the consumer-delegated model, the consumer chooses the PCS agency to perform all employer-related tasks and the agency is responsible for ensuring all service delivery to the consumer.

~~a-b.~~ The consumer-directed model allows the consumer to oversee his/her own service care delivery, and requires that the consumer work with a PCS agency acting as a fiscal intermediary agency to processing all financial paperwork to be submitted to the MCO. ~~The MCO's care coordinator is responsible for explaining both models to each consumer, initially, and annually thereafter.~~

5. CONSUMER'S RESPONSIBILITIES

- A. Consumers receiving PCS have certain responsibilities depending on the service delivery model they choose.
- a. The consumer's or legal representative's responsibilities under the consumer-delegated model include:
1. Verifying that services have been rendered and signing accurate time sheets/logs for submission to the PCS agency for payroll;
 2. Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;
 3. Allowing the PCS provider to complete monthly home supervisory visits;
 4. Participating in the CNA process, at least annually, in the consumer's primary place of residence;
 5. Participating in the development and review of the IPoC;
 6. 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
 7. Complying with all Medicaid rules, regulations, and PC service requirements; failure to comply may result in discontinuation of PCS.
- B. The consumer's or legal representative's responsibilities under the consumer-directed model include:
- a. Interviewing, hiring, training, terminating and scheduling personal care attendants; this includes, but is not limited to:
1. 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;
 2. 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
 3. Identifying training needs; this includes training his/her own attendant(s) or arranging for training for the attendant(s);
- b. 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;

- c. 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;
- d. Notifying the agency, within one business 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, photo identification, proof of eligibility to work in the United States, copy of a state driver's license and proof of insurance;
- e. Notifying and submitting a report of an incident to the PCS agency within 24 hours of such incident, so that the PCS 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;
- f. Ensuring that the individual selected for hire has submitted a request for a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq. of the Caregivers Criminal History Screening Act, within 20-calendar days of the individual beginning employment; the consumer must work with the selected agency to complete all paperwork required for submitting to the nationwide caregiver criminal history screening; the consumer may conditionally (temporarily) employ the individual contingent upon the receipt of written notice that the individual has submitted to a nationwide caregiver criminal history screening; a consumer may not continue employing an attendant who does not successfully pass a nationwide criminal history screening. The agency is responsible for the cost of the first criminal history screening and the member and/or caregiver is responsible for any additional caregiver history screenings and the associated costs thereafter if the caregiver's termination of employment is a result of termination on behalf of the member for an unjustifiable reason not related to the agencies standard employment conditions. If the caregiver quits or termination is a result of the caregiver failing to meet standard employment conditions outlined by the agency, the agency will be responsible for the criminal history screening for the next hired caregiver.
- g. Obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCS while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCS he/she will be immediately terminated; A copy of the signed agreement must be provided to the PCS;
- h. 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 PCS provided by the consumer's legal

representative must be justified, in writing, by the PCS agency and consumer and submitted for approval to the consumer's MCO prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure services were provided; documentation of written approval by the consumer's MCO must be maintained in the consumer's file; the consumer is responsible for immediately informing the agency if the consumer has appointed or obtained a legal representative any time during the plan year;

- i. 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;
 - j. Verifying prior to employment, and annually thereafter, that attendants are not on the employee abuse registry by researching the Consolidated Online Registry (COR) pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA, Section 27-7A-1 et seq.;
 - k. Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;
 - l. Allowing the PCS provider to maintain at least a minimum of quarterly in-person contact;
 - m. Participating in the CNA process, at least annually, in the consumer's primary place of residence; Participating in the development and review of the IPoC;
 - n. 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;
 - o. Complying with all Medicaid rules, regulations, and PCS requirements
- C. Consumers may have a personal representative assist him/her to give instruction to the personal care attendant or to provide information to the MCO during assessments of the consumer's natural supports and service needs. A personal representative is not the same as a legal representative, but may be the same person. A personal representative must have the following qualifications: be at least 18 years of age, have a personal relationship with the consumer and understand the consumer's natural supports and service support needs, and know the consumer's daily schedule and routine (to include medications, medical and functional status, likes and dislikes, strengths and weaknesses). A personal representative does not make decisions for the consumer unless 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 the MCO pursuant to these PCS regulations. A person's status as a personal representative must be properly documented with the PCS agency.

6. AGENCY PROVIDER REQUIREMENTS

- A. Eligible PCS Agencies: PCS agencies electing to participate in providing PCS must obtain agency certification.
- B. PCS agency certification: A PCS agency providing either the consumer-directed, the consumer-delegated, or both models, must comply with the requirements of this section. PCS agencies must be certified by Medicaid or its designee. An agency listing, by county, is maintained by Medicaid or its designee. All certified PCS 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 PCS agency must provide services in all areas of the county in which the main office is located. The PCS agency may elect to serve any county within 100 miles of the main office. The PCS agency may elect to establish branch office(s) within 100 miles of the main office. The PCS agency must provide PCS services to all areas of all selected counties.
- C. To be certified by Medicaid or its designee, agencies must meet the following conditions and submit for approval, a packet, to Medicaid's fiscal agent or its designee, containing the following:
 - a. A completed Medicaid provider participation agreement (PPA, also known as the MAD 335);
 - b. 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;
 - c. 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;
 - d. Proof of liability and workers' compensation insurance (if certified, proof of liability and workers' compensation insurance must be submitted annually to HSD and the MCO);
 - e. A copy of written policies and procedures that address:
 - 1. Medicaid's PCS provider rules and regulations;
 - 2. Personnel policies; and
 - 3. Office details 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; designation of counties served by the office;
 - ii. Meeting all Americans with Disabilities Act (ADA) requirements; and
 - iii. If PCS agencies have branch offices, the branch office must have a qualified on-site administrator to handle day-to-day operations and receive direction and supervision from the main/central office;
 - f. Quality improvement to ensure adequate and effective operation, including documentation of quarterly activity that addresses, but is not limited to:
 - 1. Service delivery;

2. Operational activities;
 3. Critical incident and significant events management practices;
 4. Quality improvement action plan; and
 5. Documentation of quality improvement activities;
- g. Agency operations to furnish services as consumer-directed or consumer-delegated, or both;
- h. 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 the requirements Paragraph (3) and Paragraph (5) (b and (d) 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;
- i. Upon request, for approval to provide the consumer-delegated model of service, a copy of the agency's written competency test for attendants approved by Medicaid or its designee; an agency may select to purchase a competency test or it may develop its own test; the test must address at least the following:
1. Communication skills;
 2. Patient/member rights, including respect for cultural diversity;
 3. Recording of information for patient/client records;
 4. Nutrition and meal preparation;
 5. Housekeeping skills;
 6. Care of the ill and disabled, including the special needs populations;
 7. Emergency response (including CPR and first aid);
 8. Universal precautions and basic infection control; Home safety including oxygen and fire safety;
 9. Incident management and reporting; and
 10. Confidentiality.
- j. 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:
1. Attend a mandatory Medicaid or its designee's provider training session prior to the delivery of PCS; and
 2. Possess a letter from Medicaid or its designee changing provider status from "pending" to "active".
- k. An agency will not be certified as a personal care agency if:
1. It is owned in full or in part by a professional authorized to complete the CNA or other similar assessment tool subsequently approved by Medicaid under PCS or the agency would have any other actual or potential conflict of interest;
 2. 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 a CNA or other similar assessment tool or authorized to carry out any of the MCO's responsibilities; a financial relationship is presumed between spouses.
- D. Approved PCS agency responsibilities: A personal care agency electing to provide PCS under either the consumer-directed model or the consumer-delegated model, or both, is responsible for:
 - a. Furnishing services to Medicaid consumers that comply with all specified Medicaid participation requirements outlined in 8.302.1 NMAC, General Provider Policies;
 - b. Verifying every month that all consumers are eligible for full Medicaid coverage and PCS prior to furnishing services pursuant to Subsection A of 8.302.1.11 NMAC, provider responsibilities and requirements; PCS agencies must document the date and method of eligibility verification; possession of a Medicaid card does not guarantee a consumer's financial eligibility because the card itself does not include financial eligibility, dates or other limitations on the consumer's financial eligibility; PCS agencies must notify consumers who are not financially eligible that he/she cannot authorize employment for his/her attendant(s) until financial eligibility is resumed; PCS agencies and consumers cannot bill Medicaid or its designee for PCS services rendered to the consumer if he/she is not eligible for PCS services;
 - c. Maintaining appropriate recordkeeping of services provided and fiscal accountability as required by the Provider Participation Agreement (PPA);
 - d. 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;
 - e. 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;

- f. Providing either the consumer-directed or the consumer-delegated models, or both models;
- g. Furnishing to their consumers, upon request, information regarding each model; if the consumer chooses a model that an agency does not offer, the agency must refer the consumer to the MCO for a list of agencies that offer the chosen model; the MCO is required to explain each model in detail to each consumer annually;
- h. Ensuring that each consumer receiving PCS services has a current approved IPoC on file;
- i. 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, and the consumer, as applicable, ensures the paperwork is submitted within the first 20-calendar days of hire; consumers under the consumer-directed model or agencies under the consumer-delegated model may conditionally (temporarily) employ an attendant until such check has been returned from the certified agency; if the attendant does not then successfully pass the nationwide caregiver criminal history screening, the agency under consumer-delegated or the consumer under consumer-directed may not continue employment of the attendant. The agency is responsible for the cost of the first criminal history screening and the member and/or caregiver is responsible for any additional caregiver history screenings and the associated costs thereafter if the caregiver's termination of employment is a result of termination on behalf of the member for an unjustifiable reason not related to the agencies standard employment conditions. If the caregiver quits or termination is a result of the caregiver failing to meet standard employment conditions outlined by the agency, the agency will be responsible for the criminal history screening for the next hired caregiver.
- j. Producing reports or documentation as required by Medicaid or its designee;
- k. Verifying that consumers will not be receiving services through the following programs while they are receiving PCS: Medicaid home and community-based services (HCBS) through the Developmentally Disabled (DD) or Medically Fragile (MF) waivers; Medicaid certified nursing facility (NF), Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID), program of all-inclusive care for the elderly (PACE), or adult protective services (APS) attendant care program; recipients of community transition goods or services may receive PCO services; all individuals must meet the Medicaid and LOC eligibility requirements to receive PCS; the MCO must conduct an assessment or evaluation to determine if the transfer is appropriate and if PCS would be

able to meet the needs of that individual; if an agency is authorized to provide services by the MCO in error, the MCO will bear the cost of the error.

- l. Processing all claims for PCS in accordance with the billing specifications from the MCO; payment shall not be issued without appropriate documentation;
- m. Making a referral to an appropriate social service, legal, or state agency, or the MCO for assistance, if the agency questions whether the consumer is able to direct his/her own care or is non-compliant with Medicaid rules and regulations;
- n. 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:
 1. 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;
 2. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer;
 3. 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;
- o. Submitting written incident reports to Medicaid or its designee, and the MCO, on behalf of the consumer, within 24 hours of the incident being reported to the PCS agency; the PCS agency must provide the consumer with an appropriate form for completion; reportable incidents may include, but are not limited to:
 1. 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;
 2. 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 Adult Protective Services (APS);
 - p. Informing the consumer and his/her attendant of the responsibilities of the agency;
 - q. Develop an IPoC based on the assessment, services authorization, task list, and consideration of natural supports provided by the MCO;
 - r. Provide an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;
 - s. Identifying a consumer with an improved or declining health condition or whose needs have changed (i.e. more or less natural supports) and believe the consumer is in need of more or fewer services should send written notification to the MCO for an LOC determination and additional assessment of need of services; and
 - t. Maintaining documentation in the consumer's file regarding legal and personal representatives, as applicable.
- E. For agencies providing PCS under the consumer-directed model, the responsibilities include:
- a. 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;
 - 1. 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
 - 2. 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;
 - b. Obtaining from the consumer or his/her legal representative a signed agreement in which the attendant agrees that he/she will not provide PCS while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCS 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;
 - c. 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; supervisory visits are not included in the consumer-directed option; however; the agency must maintain at least quarterly in-person contact with the consumer; a copy of the signed agreement must be maintained in the consumer's file;
 - d. Verifying, if the consumer has selected the consumer's legal representative as the attendant, that the consumer has obtained prior approval from Medicaid or its designee; any 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 the MCO prior to employment; the justification must demonstrate the unavailability of other qualified attendants in the applicable area, and indicate how timesheets will be verified to ensure that services were provided; documentation of written approval by the MCO must be maintained in the consumer's file; the agency must inform the consumer that if the consumer selects a legal representative during the plan year, the consumer must notify the agency immediately, and the agency must ensure appropriate documentation is maintained in the consumer's file;

- e. Establishing and explaining to the consumer necessary payroll documentation for reimbursement of PCS;
 - f. Performing payroll activities for the attendants, such as, but not limited to, state and federal income tax and social security withholding and making payroll liability payments;
 - g. Arranging for unemployment coverage and workers' compensation insurance;
 - h. 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;
 - i. Making a referral to an appropriate social service agency, legal agency(s) or Medicaid designee for assistance, if the agency questions the ability of the consumer to direct his/her own care; and
 - j. Maintaining a consumer file, and an attendant personnel file for the consumer, for a minimum of six years.
- F. For agencies providing PCS under the consumer-delegated model, the responsibilities include, but are not limited to the following:
- a. Employing, terminating and scheduling qualified attendants;
 - b. Conducting or arranging for training of all attendants for a minimum of 12 hours annually; initial training must be completed within the first three months of employment and must include:
 - 1. An overview of PCS;
 - 2. Living with a disability or chronic illness in the community;
 - 3. CPR and first aid training; and
 - 4. A written competency test with a minimum passing score of at least 80 percent; expenses for all training are to be incurred by the agency; other training may take place throughout the year as determined by the agency; the agency must maintain in the attendant's file: copies of all training certifications; CPR and first aid certifications must be current;
 - 5. Documentation of all training must include at least: name of trainee, title of the training, source, number of hours, and date of training;
 - 6. Documentation of competency testing must include at least the following: name of individual being evaluated, date and method

used to determine competency, and a copy of the attendant's graded competency test indicating a passing score of at least 80 percent; special accommodations must be made for attendants who are not able to read or write, or who speak, read, or write only language(s) other than English;

- c. Developing and maintaining a procedure to ensure trained, qualified attendants are available as backup for regularly scheduled attendants, and for emergency situations; complete instructions regarding the consumer's care and a list of attendant responsibilities must be available in each consumer's home;
- d. Informing the attendant of the risks of hepatitis B infection per current department of health (DOH) or the center for disease control and prevention (CDC) recommendation, and offering hepatitis B immunization at the time of employment at no cost to the attendant; attendants are not considered to be at risk for hepatitis B since only non-medical services are performed, therefore attendants may refuse the vaccine; documentation of the immunization, prior immunization, or refusal of immunization must be in the attendant's personnel file;
- e. 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;
- f. Complying with federal and state labor laws;
- g. Preparing all documentation necessary for payroll;
- h. Complying with Medicaid participation requirements outlined in 8.302.1 NMAC, General Provider Policies;
- i. Maintaining records sufficient to fully disclose the extent, duration, and nature of services furnished to the consumers as outlined in 8.302.1 NMAC, General Provider Policies;
 - 1. The PCS agency may elect to keep a log/check list, in addition to the timesheet, in the consumer's home, describing services provided on a daily basis; if a log/check list is maintained, the log must be compared with the weekly timesheet and copies of both the timesheet and the log/check list must be kept in the consumer's file;
 - 2. The PCS 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 verification by the consumer or the consumer's legal representative; failure by a PCS agency to maintain a proper record for audit under this system will subject the PCS agency to recovery by Medicaid of any insufficiently documented claims;

- j. Obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCS while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCS, he/she will be immediately terminated;
 - k. 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 PCS provided by the consumer's legal representative must be justified in writing by the agency and consumer and submitted for approval to the MCO prior to employment; the justification must demonstrate the unavailability of other qualified attendants in the applicable area and include a plan for oversight by the agency to assure service delivery; documentation of approval by the MCO must be maintained in the consumer's file; the agency must inform the consumer that if the consumer is appointed or selects a legal representative any time during the plan year, they must notify the agency immediately;
 - l. Establishing and explaining to all their consumers and all attendants the necessary documentation needed for reimbursement of PCS;
 - m. Performing payroll activities for the attendants;
 - n. Providing workers' compensation insurance for attendants;
 - o. Conducting face-to-face supervisory visits in the consumer's residence at least monthly (12 per service plan year); each visit must be documented in the consumer's file indicating:
 - 1. Date of visit;
 - 2. Time of visit to include length of visit;
 - 3. Name and title of person conducting supervisory visit;
 - 4. Individuals present during visit;
 - 5. Review of IPoC;
 - 6. Identification of health and safety issues and quality of care provided by attendant, and
 - 7. Signature of consumer or consumer's legal representative;
 - p. Maintaining an accessible and responsive 24-hour communication system for consumers to use in emergency situations to contact the agency;
 - q. Following current recommendations of DOH and CDC, as appropriate, for preventing the transmission of TB; and
 - r. 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.
- G. Personal Care Attendant Responsibilities: Personal care attendants providing PCS for consumers electing either consumer-directed or consumer delegated must comply with the following responsibilities and requirements. They include:
- a. Being hired by the consumer (consumer-directed model) or the PCS 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 PCS agency (consumer-delegated), with proof of and copies of their 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 the MCO; any personal care services provided by the consumer's legal representative must be justified, in writing, by the PCS agency, and consumer, having been submitted for written approval to the MCO prior to employment; the justification must demonstrate the unavailability of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure that services were provided; documentation of approval by the MCO must be maintained in the consumer's file; and submit appropriate documentation of time worked and services performed ensuring that he/she has signed his/her time sheet/log/check 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-calendar days of hire; an attendant may be conditionally hired by the agency contingent upon the receipt of written notice from the certified agency of the results of the nationwide criminal history screening; attendants who do not successfully pass a nationwide criminal history screening are not eligible for further PCS employment. The agency is responsible for the cost of the first criminal history screening and the member and/or caregiver is responsible for any additional caregiver history screenings and the associated costs thereafter if the caregiver's termination of employment is a result of termination on behalf of the member for an unjustifiable reason not related to the agency's standard employment conditions. If the caregiver quits or termination is a result of the caregiver failing to meet standard employment conditions outlined by the agency, the agency will be responsible for the criminal history screening for the next hired caregiver.
- g. Ensuring while employed as an attendant he/she will not be under the influence of drugs or alcohol while performing PCS; the attendant must complete and sign an agreement with the agency or consumer in which the attendant acknowledges that if he/she is under the influence of drugs or alcohol while providing PCS he/she will be immediately terminated;
- h. May not be the consumer's 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 PCS; 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 at least 80 percent correct within the first three months of employment.

H. Coverage Criteria: PCS have been established to assist individuals 21 years of age or older who are eligible for full Medicaid benefits and meet the NF LOC criteria. PCS are defined as those tasks necessary to avoid institutionalization and maintain the consumer's functional level and independence. PCS are for consumers who meet NF LOC because of disability or functional limitation and need assistance with certain ADLs and IADLs. PCS are allocated for a reasonable accommodation of tasks to be performed by a personal care attendant, but do not provide 24-hours per day services. A CNA is conducted pursuant to this policy, assessments for services, to determine the amount and type of services needed to supplement the services a consumer is already receiving including those services provided by natural supports. PCS are not provided 24 hours a day and allocation of time and services must be directly related to an individual's functional level to perform ADLs and IADLs as indicated in the CNA.

- a. PCS are usually furnished in the consumer's residence, except as otherwise indicated, and during the hours specified in the consumer's IPoC. Services may be furnished outside the residence only when appropriate and necessary and when not available through other existing benefits and programs, such as 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 MCO will perform a CNA and ensure that the PCS 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, PCS cannot duplicate those services. Regulations for

assisted living facilities may be found at 7.8.2 NMAC, Assisted Living Facilities for Adults.

- b. PCS are not furnished to an individual who is an inpatient or resident of a hospital, NF, ICF/IID, 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. PCS are not intended to replace natural supports. Service hours will be allocated, as appropriate, to supplement the natural supports available to a consumer. Consumers that reside with other adult household members, that are not receiving PCS or are not disabled, will be presumed to have household services in the common/shared areas provided by the other adult residents, whether or not the adult residents are the selected personal care attendant. Personal care attendants that live with the consumer will not be paid to deliver household services, support services (shopping and errands), or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., cleaning consumer's room, linens, clothing, and special diets). If a consumer's living situation changes:
 - 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.
- I. Covered Services: PCS are provided as described in 8.308.12.13 NMAC. PCS will not include those services for tasks the individual does not need or is already receiving from other sources including tasks provided by natural supports. PCS must be related to the individual's functional level to perform ADLs and IADLs as indicated in the CNA conducted pursuant to this policy, assessments for services, mobility assistance, either physical assistance or verbal prompting and cueing, may be provided during the administration of any PCS task by the attendant. Mobility assistance includes assistance with ambulation, transferring, or repositioning, which is defined as moving around inside or outside the residence or consumer's living area with or without assistive devices(s) such as walkers, canes, and wheelchairs, or changing position to prevent skin breakdown.
- a. Certain PCS are provided only when the consumer has the ability to self-administer. Ability to self-administer is defined as the ability to identify and communicate medication name, dosage, frequency and reason for the medication. A consumer who does not meet this definition of ability to self-administer is not eligible for these services.
 - b. When two or more consumers living in the same residence, including assisted living facilities, shelter homes, and other similar living arrangements, are receiving PCS, they will be assessed both individually and jointly to determine services that are shared. Consumers sharing

living space will be assessed for services identified in Paragraphs (5) and (7) of Subsection I of 8.308.12.13 NMAC: assess each consumer individually to determine if the consumer requires unique assistance with the service; and jointly with other household members to determine shared living space and common needs of the household; services will be allocated based on common needs, not based on individual needs, unless as assessed by the MCO, an individual need for the service(s) is indicated; common needs may include meals that can be prepared for several individuals; shopping/errands that can be completed at the same time; laundry that can be completed for more than one individual at the same time; dusting and vacuuming of shared living spaces; these PCS are based on the assessment of combined needs in the household without replacing natural and unpaid supports identified during the assessment.

c. Description of PCS refer to 8.308.12.13 NMAC.

J. Assessments for Services: After the consumer is determined medically eligible for PCS, the MCO determines, allocates, and authorizes PCS based on a functional assessment, which is part of the CNA process. Although a consumer's assessment for the amount and types of services may vary, PCS are not provided 24 hours a day. An individual's PCS are directly related to their functional level to perform ADLs and IADLs as indicated by the CNA. The CNA is performed when a consumer enters the program, at least annually or at the discretion of the MCO.

a. The CNA determines the type of covered services needed by the consumer. The amount of time allocated to each type of covered service is determined by applying and recording the individual's functional level to perform ADLs and IADLs. PCS are allocated for a reasonable accommodation of tasks to be performed by a personal care attendant. A CNA determines the amount and type of PCS needed to supplement and not duplicate the services a consumer is already receiving including those services provided by natural supports. In the event that the consumer's functional needs exceed the average allocation of time allotted to perform a particular service task per the recommendation of a medical professional, the MCO may consider authorization of additional time based on the consumer's verified medical and clinical need.

b. The CNA is conducted by the MCO and discussed with the consumer in the consumer's primary place of residence. It serves to document the current health condition and functional needs of the consumer. It is to include no duplication of services a consumer is already receiving, including those services provided by natural supports, and shall not be based on a prior assessment of the consumer's health condition, functional needs, or existing services.

c. The completed CNA or personal care service allocation tool is sent to the PCS agency by the MCO to allow the PCS agency to develop the IPoC.

d. The CNA must be performed by the MCO upon a consumer's initial approval for medical NF LOC eligibility to receive PCS and at least annually thereafter, based on their assigned care coordination level or at

the MCO's discretion. The annual CNA is completed prior to the expiration of the current NF LOC period and determines the type and amount of services for the subsequent NF LOC period. The type and amount of PCS as determined by the CNA shall not be effective prior to the start of the applicable NF LOC period. An interim assessment may be conducted if:

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 MCO must explain each service delivery model at least annually to consumers enrolled in Agency Based Community Benefits (ABCB).
- e. The MCO will issue a prior authorization (PA) to the PCS agency. A PCS authorization cannot extend beyond the LOC period and must be provided to the PCS agency prior to the PA effective date and may not be applied retroactively.
- f. A PCS consumer who disagrees with the authorized number of hours may utilize the MCO grievance and appeal process when enrolled in managed care. The consumer must exhaust the appeals process with the MCO before a fair hearing can be requested pursuant to 8.352.2 NMAC, Recipient Hearings. Upon notification of the resolution of the appeal or grievance, a member may request a fair hearing with the State. The MCO may schedule a pre-hearing conference with the consumer to explain how the PCS regulations were applied to the authorized service time, and attempt to resolve issues prior to the fair hearing.
- g. Continuation of benefits: A member may continue PCS benefits while an MCO grievance and appeal or state fair hearing decision is 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.
- h. The member shall be responsible for repayment of the cost of the services furnished while the MCO grievance and appeal process or the state's fair hearing process was pending, to the extent 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 MCO may recover these costs from the member, not the provider.
- K. Individual Plan of Care (IPOC): An IPOC is developed, and PCS are identified, with the appropriate assessment (CNA) for allocating PCS. The PCS agency develops an IPOC using an MCO authorization. The finalized IPOC must contain a seven-day schedule, unless natural supports are identified or any other supporting documentation which indicates the member is self-sufficient for any other days of the week which are not included in the seven-day schedule. Only those services identified as IADLs, household support services, or certain ADL PCS such as meal preparation may be moved to another day, using the IPOC. The PCS agency must

document more, and less, service time on the IPoC for specific day(s) during the week so 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 calendar days if a consumer receives services only four calendar days during the week). Any tasks not performed by the attendant cannot be “banked” or otherwise saved for a later date.

a. The PCS 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 consumer’s signature on the IPoC indicates that the consumer understands what services have been identified and that services will be provided on a weekly basis for a maximum of one year; if a consumer is unable to sign the IPoC and the consumer does not have a legal representative, a thumbprint or personal mark (i.e., an “X”) will suffice; if signed by a legal representative, Medicaid or its designee and the agency must have documentation in the consumer’s file verifying the individual is the consumer’s legal representative;
3. Maintain an approved IPoC for PCS for a maximum of one year (12 consecutive months), a new IPoC must be developed at least annually, to ensure the consumer’s current needs are being met; a consumer’s previous year IPoC is not used or considered in developing a new IPoC and allocating services; a new IPoC must be developed independently at least every year based on the consumer’s current medical condition; the tasks and number of hours in the IPoC must match the authorized tasks and number of hours on the authorization;
4. Submit the proposed IPoC to the MCO for final review and approval;
5. Provide the consumer with a copy of their approved IPoC;
6. Obtain an approved task list and/or CNA;
7. Obtain written verification that the consumer, or the consumer’s legal representative, understands that if the consumer does not utilize services, for two months, the full amount of allocated services on the IPoC, that these circumstances will be documented in the consumer’s file; and
8. Submit a personal care transfer/closure form (MAD 062 or other approved transfer/closure form) to the MCO for a consumer who has passed away or who has not received services for 90-consecutive days.

- L. PCS are to be delivered only in the state of New Mexico. However, consumers who require PCS out of the state, for medically necessary reasons, may request and exception, and must obtain written approval from the MCO for out-of-state delivery of service prior to leaving the state. The following must be submitted for consideration when requesting medically necessary out-of-state services:
- a. A letter from the consumer or the consumer's legal representative requesting an out-of-state exception and reasons for the request; the letter must include:
 1. The consumer's name and social security number;
 2. How time sheets/logs/check-off list will be transmitted and payroll checks issued to the attendant;
 3. Date the consumer will be leaving the state, including the date of the medical procedure or other medical event, the anticipated date of return; and
 4. Where the consumer will be housed after the medical procedure.
 - b. A letter or documentation from the physician, surgeon, physician assistant, nurse practitioner, or clinical nurse specialist verifying the date of the medical procedure; and
 - c. A copy of the consumer's approved IPoC and a proposed adjusted revision of services to be provided during the time the consumer is out-of-state; support services and household services will not be approved unless justified; if the consumer has been approved for services under self-administered medications, a statement from the physician, physician assistant, nurse practitioner, or clinical nurse specialist must be included indicating the consumer will continue to have the ability to self-administer for the duration of time he/she is out-of-state.
 1. Utilization Review (UR): All PCS require prior LOC approval by the MCO; therefore, retroactive services are not authorized. All PCS are subject to utilization review for medical necessity and program compliance. The MCO will perform utilization review for medical necessity. The MCO makes final authorization of PCS using:
 2. The HSD-approved LOC criteria; and
 3. The CNA.

~~M. Transfer/Closure Process for PCS: A consumer wishing to transfer services to another Medicaid approved PCS agency may request a personal care transfer/closure form (MAD-062 or other approved transfer/closure form). Transfers within the plan year may be requested by the consumer, but must be approved by the MCO prior to the agency providing PCS to the consumer. All requests for change of service model (from/to directed/delegated) must be approved by the MCO prior to the receiving agency providing services to the consumer. Transfers may only be initiated by the consumer or his/her legal representative and may not therefore be requested by the attendant. The transfer process is determined by the MCO and should be initiated by the consumer through the consumer's assigned care coordinator. The consumer must give the reason for the requested transfer.~~

- a. ~~A transfer requested by a consumer may be denied by the MCO 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 PCS regulations and procedures; and~~
 9. ~~There is reason to believe that solicitation has occurred as defined in this policy in the, Solicitation/Advertising section in this policy.~~
- b. ~~The MCO will notify the consumer and both the originating agency and the receiving agency of its decision within 15 working days after receiving the request. The consumer may verify that his/her request was received by the MCO.~~
- c. ~~A consumer who does not agree with the MCO's decision shall utilize the MCO grievance and appeal process. Upon receiving notification of the resolution of the appeal or grievance by the MCO, a consumer may request a fair hearing pursuant to 8.352.2 NMAC, Recipient Hearings. The originating agency is responsible for the continuance of PCS while the hearing is pending, if requested timely by the consumer and approved by the MCO, as identified in the assessments for services section of this policy.~~
- d. ~~The following is the process for submitting a transfer request:~~
 1. ~~The consumer must inform the MCO of the desire to transfer to another PCS agency; the MCO approves or denies the transfer request; if approved, the MCO works with both the agency from which he/she is currently receiving services (originating agency) and the agency to which he/she would like to transfer (receiving agency) to complete the transfer.~~
 2. ~~Originating agencies are responsible for continuing service provision until the transfer is complete.~~
 3. ~~Both the originating and receiving PCS agencies are responsible for following transfer procedures.~~
 4. ~~After the MCO verifies the consumer's request, the MCO will process the transfer request within 15 business days after receiving the transfer request.~~

5. ~~The MCO 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 with new dates of service and units remaining for the remainder of the IPoC year; the MCO will notify the consumer as well as the receiving PCS agency and issue an ending authorization to the originating agency.~~

M. PCS Agency Transfer Process: A consumer requesting to transfer services from one PCS agency to another Medicaid approved PCS agency may request a transfer form (MAD 062 or other approved transfer/closure form) from his/her~~their~~ MCO. Transfers may only be initiated by the consumer, his/her legal representative, or by a PCS agency on behalf of a consumer or his/her legal representative. Transfer requests shall not be requested by the personal care attendant. Transfer approvals are determined by the MCO and should be initiated by the consumer through the consumer's assigned care coordinator.

The following outlines the process for PCS Agency Transfers:

- a. The consumer must inform his/her~~their~~ MCO of the desire to transfer to another PCS agency;
- b. The consumer must complete a MAD 062 or an approved transfer form to include: the consumer's signature; the date of ²-the signature of the receiving PCS agency; and the justification for the transfer.
- c. The MCO will process the transfer request within 15 business days after receipt of the transfer request.
- d. If approved, the MCO works with both the agency from which the consumer is currently receiving services (originating agency) and the agency to which the consumer would like to transfer (receiving agency) to complete the transfer.
- e. Originating agencies are responsible for continued provision of services until the transfer is complete.
- f. Upon approval of the request, the MCO will issue a new prior authorization to the receiving agency and make the transfer date effective 10 business days from the date of processing the transfer. The prior authorization will include: a new prior authorization number and new dates of service and units remaining for the remainder of the IPOC year.
- g. The MCO will notify the consumer as well as the receiving PCS agency and issue an ending authorization to the originating agency.

The following outlines the MCO review process for PCS Agency Transfers:

1. When the MCO receives a request for a transfer from a consumer or PCS agency on behalf of a consumer or his/her legal representative, the consumer's Care Coordinator will interview the consumer to determine if the request is **consumer-driven**.

2. The Care Coordinator will ask the consumer or his/her legal guardian for specific reasons for the transfer, including but not limited to: Will you be taking your caregiver with you? If the consumer is taking his/her caregiver, the Care Coordinator should ask why the consumer is requesting a transfer.
3. The Care Coordinator will contact the originating and the receiving agency to investigate the reasons given by the consumer and/or legal representative. In addition, the Care Coordinator will ensure the consumer has notified both agencies.
4. If, during the review process, the MCO determines that the originating and/or receiving agency is not compliant with the applicable Medicaid regulations, the MCO shall conduct an audit of the agency and if necessary provide additional training or impose a corrective action plan. For example, if the receiving agency has engaged in solicitation, or if the originating agency is not sending back-up caregivers or the caregivers are not showing up on the scheduled days or for the hours care is planned for, these issues would need to be addressed by the MCO and corrected by the agencies.
5. If, during the course of the review process, the Care Coordinator finds that the consumer has requested several transfers within a six month period, the Care Coordinator shall meet with the consumer and/or legal guardian to try to determine the reason for such requests and to consider whether to approving or denying the transfer.
6. The consumer and/or legal guardian will not be allowed to hire an individual to be his/her attendant who has not passed a nationwide criminal history screening or an attendant that has been terminated from another agency for fraudulent activities or other misconduct. The Care Coordinator will educate the consumer about of the Medicaid PCS policies.
7. When reviewing a transfer request, tThe MCO should take into consideration when reviewing a transfer request whether the consumer can speak and read English. If the consumer does not speak or read English, the MCO shall provide a translator to ensure that the consumer's options have been explained and that the consumer fully understands his/her options, and that the service model selected is available to the consumer.
8. The Care Coordinator should ensure that the location of the agency or provider is convenient to the consumer.
9. A consumer who does not agree with the MCO's decision shall utilize the MCO grievance and appeal process.
10. Upon receiving notification of the resolution of the appeal or grievance by the MCO, a consumer may request a fair hearing pursuant to 8.352.2 NMAC, Recipient Hearings.
11. The originating agency is responsible for the continuance of PCS while the hearing is pending, if continuation of benefits is requested timely by the consumer and approved by the MCO.

All requests for change of service model (from/to directed/delegated) must be approved by the MCO prior to the receiving agency providing services to

the consumer.

- N. Consumer Closure: The transfer/closure form may also be used by a consumer or PCS agency to initiate closure of PCS for a member who has gone 90 consecutive days or more without PCS. The PCS agency will submit the transfer/closure form to the MCO and the MCO will call and verify with the consumer that PCS are no longer needed or wanted. After verification is received the MCO will provide an end authorization to the PCS agency.
- O. Consumer Discharge: A consumer may be discharged from a PCS agency or may be discharged by HSD from receiving any PCS.
- P. PCS Agency Discharge: The PCS agency may discharge a consumer for a justifiable reason, as explained below. Prior to initiating discharge, the PCS agency must send a notice to the MCO for approval. Once approved by the MCO, the PCS agency may initiate the discharge process with a 30-day written notice to the consumer. The notice must include the consumer's right to request an appeal with the MCO and that he/she must exhaust the grievance and appeal process with the MCO before a fair hearing can be filed with HSD pursuant to 8.352.2 NMAC, Recipient Hearings. The notice must include the justifiable reason for the agency's decision to discharge.
 - a. A justifiable reason for discharge may include:
 - 1. Staffing problems (i.e., excessive request for change in attendants, such as three or more during within 30 calendar days);
 - 2. 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, or intimidating behavior; the agency or attendant must have documentation demonstrating the pattern of abuse; the agency may also discharge a consumer if the life or safety of an attendant or agency's staff member is believed is in immediate danger;
 - 3. A consumer or family member demonstrates a pattern of uncooperative behavior including not complying with agency or Medicaid regulations; not allowing the PCS agency to enter the home to provide services; and continued requests to provide services not approved on the IPoC;
 - 4. Illegal use of narcotics or alcohol abuse;
 - 5. Fraudulent submission of timesheets; or
 - 6. Living conditions or environment that may pose a health or safety risk or cause harm to the personal care attendant, employee of an agency, MCO, or other Medicaid designee.
 - b. The MCO must provide the consumer with a current list of Medicaid-approved personal care agencies that service the county in which the consumer resides. The PCS agency must assist the consumer in the discharge process, cooperate with the MCO, and continue services throughout the discharge. If the consumer does not select another PCS agency within the 30-day time frame, the current PCS agency must inform the MCO's care

coordinator and the consumer that a lapse in services will occur until the consumer selects an agency.

- c. A consumer has a right to appeal the PCS agency's decision to suspend services. The consumer must exhaust the MCO grievance and appeal process prior to requesting a fair hearing with HSD as outlined in 8.352.2 NMAC, Recipient Hearings.
 - a. Discharge by the state: Medicaid or its designee reserves the right to discontinue the consumer's receipt of PCS due to the consumer's non-compliance with Medicaid regulations and/or PCS requirements. The discontinuation of PCS does not affect the consumer's Medicaid eligibility. The consumer may be discharged for a justifiable reason by means of a 30-day written notice to the consumer. The notice will include the duration of discharge, which may be permanent, the consumer's right to request a fair hearing, pursuant to 8.352.2 NMAC, Recipient Hearings, and the justifiable reason for the discharge. A justifiable reason for discharge may include:
 - b. Staffing problems (i.e., unjustified excessive requests for change in attendants, such as three or more during a 30-day period), excessive requests for transfers to other agencies or excessive agency discharges;
 - c. A consumer who demonstrates a pattern of verbal or physical abuse toward attendants, agency personnel, or state staff or contractors, including use of vulgar or explicit sexual language, verbal or sexual harassment, excessive use of force, demonstrates intimidating behavior, verbal or physical threats toward attendants, agency personnel, or state staff or contractors;
 - d. A consumer or family member who demonstrates a pattern of uncooperative behavior including, noncompliance with agency, Medicaid program requirements or regulations or procedures;
 - e. Illegal use of narcotics, or alcohol abuse;
 - f. Fraudulent submission of timesheets; or
 - g. Unsafe or unhealthy living conditions or environment.
 - h. PCS agencies and the MCO are responsible for documenting and reporting any incidents involving a consumer to Medicaid or its designee.

7. REIMBURSEMENT

A Medicaid-approved PCS agency will process billings in accordance with the MCO billing instructions. Reimbursement for PCS will be based on the negotiated rate with the MCO.

The agency's billed charge must be the usual and customary charge for services. "Usual and customary charge" refers to the amount an individual provider charges the general public in the majority of cases for a specific service and level of service.

8. PCS PROVIDER VOLUNTARY DISENROLLMENT

A Medicaid approved PCS agency may choose to discontinue provision of services by disenrollment. Once approved by Medicaid or its designee, the PCS agency may initiate the disenrollment process to assist consumers to transfer to another Medicaid approved PCS agency. The PCS agency must continue to provide services until consumers have

completed the transfer process and the agency has received approval from Medicaid or its designee to discontinue services. Prior to disenrollment, the PCS agency must send a notice to Medicaid or its designee for approval. The notice must include:

- 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.

9. SOLICITATION/ADVERTISING

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

- A. Prohibited solicitation includes, but is not limited to, the following:
 - a. Contacting a consumer who is receiving services through another PCS or any another Medicaid program;
 - b. Contacting a potential consumer to discuss the benefits of its agency, including door to door, telephone, mail and email solicitation;
 - c. Offering a consumer/attendant a finder fee, higher wage, kick back, or bribe consisting of anything of value to the consumer to obtain transfers to its agency; see 8.351.2 NMAC, Sanctions and Remedies;
 - d. 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;
 - e. Making false promises;
 - e.f. Misinterpretation or misrepresentation of Medicaid rules, regulations or eligibility;
 - f.g. Misrepresenting itself as having affiliation with another entity; and
 - g.h. Distributing PCS-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 PCS provision must first get prior written approval from Medicaid or its designee before conducting any such activity. Advertising and community outreach materials means materials that are produced in any medium, on behalf of a PCS agency and can reasonably be interpreted as advertising to potential clients. Only approved advertising materials may be used to conduct any type of community outreach. Advertising or community outreach materials must not misrepresent the agency as having affiliation with another entity or use proprietary titles, such as "Medicaid PCS". Any PCS agency conducting any such activity without prior written approval from Medicaid or its

designee will be subject to sanctions and remedies as provided in 8.351.2 NMAC and applicable provisions of the PPA.

10. 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.

PRIVATE DUTY NURSING FOR ADULTS

Private Duty Nursing Services provide members who are 21 years of age and older with intermittent or extended direct nursing care in the member's home. All services provided under Private Duty nursing require the skills of a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under a written physician's order in accordance with the New Mexico Nurse Practice Act, Code of federal Regulation for Skilled Nursing. Nursing services are planned in collaboration with the physician, the member, and the MCO Care Coordinator. All services provided under Private Duty Nursing are pursuant to a physician's order and in conjunction with the MCO. The private duty nurse will develop and implement a Plan of Care/Treatment (CMS form 485) that is separate from the Care Plan that is developed by the MCO. Community Benefit Service members do not have to be homebound in order to receive this service. Community Benefit Service Private Duty Nursing and Medicare/Medicaid Skilled nursing may not be provided at the same time. The Private Duty Nursing service offered through the Community Benefit Service program will vary in scope and duration from Medicare and Medicaid skilled nursing. Private Duty Nursing services will be offered to members who are 21 years of age and older receiving the Community Benefit Service as the provider of last resort in accordance with the State Medicaid Plan, State Medicaid Manual, Part 4, Section 4310 and Section 4442.1. A copy of the written referral will be maintained in the member's file by the private duty nursing provider and shared with the MCO. Children (individuals under the age of 21) receive this service through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Specific services may include the following;

1. SCOPE OF SERVICES

- A. Obtaining pertinent medical history.
- B. Observing and assessing the member's condition.
- C. Administration of medications to include: oral, parenteral, gastrostomy, jejunostomy, inhalation, rectal and topical routes.
- D. Providing wound care, suture removal and dressing changes.
- E. Monitoring feeding tubes (i.e. gastrostomy, naso-gastric, or jejunostomy including patency), including signs of possible infection
- F. Monitoring bladder program and providing care, including ostomy and indwelling catheter insertion and removal.
- G. Monitoring aspiration precautions.
- H. Monitoring administration of oxygen, ventilator management, and member's response.
- I. Monitoring infection control methods.
- J. Monitoring seizure protocols.
- K. Collecting specimens (blood, urine, stool, or sputum) and obtaining cultures as ordered by the member's primary physician.
- L. Alerting the member's physician to any change in health status.

- M. Monitoring nutritional status of the member and reporting any changes to the physician and nutritionist if available.
- N. Maintaining member intake and output flow sheets as ordered by the physician.
- O. Performing physical assessments including monitoring of vital signs and the member's medical condition as warranted.
- P. Providing education and training to the member's appropriate family member(s) and primary caregiver(s) regarding care needs and treatments etc. The goal for education and training is to encourage self-sufficiency in delivery of care by the family or primary caregiver.
- Q. Providing staff supervision of appropriate activities, procedures and treatment.
- R. The Plan of Care/Treatment will be developed in collaboration with the member, and the MCO Care Coordinator. The plan will identify and address the member's specific needs in accordance with the physician's orders. Develop and implement the Plan of Care/Treatment (CMS form 485) on the basis of the member assessment and evaluation.
- S. Analyze and interpret member's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings.
- T. Develop interventions to assist the member to achieve and promote health to meet the individual member's needs.
- U. Develop individualized service goals, identifying short-and long-term goals that are measurable and objective.
- V. Document dates and types of treatments performed, as well as member's response to treatment and progress toward all goals.

2. SERVICE REQUIREMENTS

- A. The private duty nurse must perform a comprehensive assessment/evaluation for each member and coordinate with the MCO Care Coordinator to determine appropriate services annually at a minimum or at each visit.
- B. Private Duty Nursing Services listed in the Care Plan are to be within the scope of the New Mexico Nurse Practice Act, are provided subsequent to obtaining a physician's order, under the supervision of a Registered Nurse (RN). Physician's orders will contain the following:
 - a. The task to be performed,
 - b. How frequently the task is to be performed,
 - c. The duration that the order is applicable,
 - d. Any individualized instructions. Additionally a physician's order will be obtained for the revision of any nursing service and annually with the Individual Service Plan renewal, if nursing services are to continue.
- C. The Private Duty Nursing Supervisor will provide clinical supervision in the member's home at a minimum of once each quarter.
- D. Supervision of Private Duty Nursing Services must be documented in the member's clinical record.
- E. The Plan of Care/Treatment (Form CMS-485) will be provided to the MCO. Within 48 hours of any changes ordered by the physician, the provider agency will inform the MCO Care Coordinator of physician ordered changes and the agency's ability or inability to provide Private Duty Nursing in accordance with

the Care Plan. The provider agency will provide the MCO with a copy of revised orders.

- F. Submitting initial and quarterly progress reports to the MCO. Copies of quarterly progress reports sent to the MCO will be maintained in the member file and will include an assessment of the member's current status, health and safety issues and the progress goals as listed on the plan of care/treatment.
- G. Reviewing and revising the nursing plan of care/treatment making appropriate treatment modifications as necessary and coordinate with the MCO Care Coordinator of the changes that may need to be identified and/or changed on the Care Plan.
- H. Document complications that delay, interrupt, or extend the duration of the services in the member's medical record as well as communication with the member's physician.
- I. Reviewing physician's request for treatment. If appropriate, recommend revisions to the Care Plan to the MCO Care Coordinator by requesting a conference.
- J. Providing member and/or caregiver education regarding services. Document the date and time this occurred in the member's clinical file.

3. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

A. Staffing Requirements.

- a. A Registered Nurse (RN) or Licensed Practical Nurse (LPN) is considered a qualified private duty nurse when the following criteria are met.
- b. Must have current licensure as required by the state of New Mexico.
- c. Nursing experience preferably with disabled and elderly individuals. This includes settings such as home health, hospital, nursing home facility, or other types of clinics and institutions.
- d. Nursing services must be furnished through a licensed Home Health Agency, licensed Rural Health Clinic or certified federally Qualified Health Center.
- e. Registered Nurses who supervise should have at least one year of supervisory experience. Supervision of licensed practical nurses must be provided by a registered nurse and shall be in accordance with the New Mexico Nursing Practice Act. The supervision of all personnel is the responsibility of the agency's Administrator and Director.
- f. Be culturally sensitive to the needs and preferences of member s and their households based upon language. Communicating in a language other than English may be required.
- g. Hepatitis B vaccine will be offered by the provider agency upon employment at no cost to the employee per the federal OSHA requirements. Record of prior Hepatitis B immunization, acceptance or denial by the employee will be maintained in the employee's personnel record.

B. Administrative Requirements

- a. Must comply with all applicable state and federal rules and regulations for licensed home health agencies and program standards determined by HSD/MAD including but not limited to Criminal Background Checks,

OSHA training requirements, Incident Management System reporting, Labor Laws and etc.

- b. All services must be under the order of the member's Primary Care Physician. The order will be obtained by an RN working for the agency that provides private duty nursing services, and will be shared with the MCO.
- c. Reports must be current and available upon request of HSD/MAD.

4. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies his or her role in all components of the provision of nursing services, including assessment information, care planning, intervention, communications, and evaluation. There must be justification in each member's clinical record supporting medical necessity for the care and for the level or intensity (frequency and duration) of the care. All services must be reflected on a Care Plan that is coordinated with the member/member representative, other caregivers as applicable, and authorized by the MCO. All services provided, claimed, and billed must have documented justification supporting medical necessity and must be covered by the ABCB. Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for private duty nursing for adults' services will be based on the negotiated rate with the MCOs. Providers have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

- A. Payment for private duty nursing services through the MCO is considered payment in full.
- B. Private duty nursing services must abide by all federal, state, HSD, policies and procedures regarding billable and non-billable items.
- C. Billable hours are as follows:
 - a. Face-to-face activities that are described above in the Scope of Service for Private Duty Nursing.
 - b. Attendance and/or telephone conference call to participant in interdisciplinary team meetings.
 - c. Development of the plan of care/treatment, not to exceed four (4) hours annually.
 - d. Reimbursement is on a unit rate per hour and rounded to the nearest quarter.
 - e. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.
- D. HSD/MAD does not consider the following to be professional private duty nursing services and will not authorize payment for the following non-billable activities:
 - a. Performing specific errands for the individual and/or family that are not program specific.
 - b. Friendly visiting.

- c. Financial brokerage services, handling of member finances, or preparation of legal documents.
 - d. Time spent on paperwork or travel that is administrative for the provider.
 - e. Transportation of members.
 - f. Pick up and/or delivery of commodities.
 - g. Other non-Medicaid reimbursable activities.
- E. Private duty nursing services are provided with the understanding that the MCO is the payer of last resort. ABCB services should not be requested or authorized until all other third party and community resources have been explored and/or exhausted. If services are available for reimbursement through third party liability or other payment sources, these sources must be accessed before ABCB services are delivered.
- F. Private duty nursing services ensure all insurance records are maintained correctly.
- G. Reimbursement for private duty nursing services will be based on the current negotiated with the MCO the services. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.
- H. The ABCB does not provide 24 continuous hours of nursing services for any member except as a Private Duty Nursing Respite service provider. This does not preclude the use of other funding sources for nursing such as Medicare or private pay etc., to supplement ABCB Service nursing services for a member.

NURSING RESPITE SERVICES

Nursing Respite services provide the member's primary caregiver with a limited leave of absence to prevent burnout and provide temporary relief to meet a family crisis, emergency or caregiver's illness as determined in the Care Plan. A primary caregiver is the individual who has been identified in the Care Plan and who assists the member on a frequent basis, i.e. daily or at a minimum weekly. It is not necessary for the primary caregiver to reside with the member in order to receive respite services. Nursing Respite services may be provided in the member's home, in the respite provider's home and in the community. Nursing Respite services may be provided by a Registered Nurse (RN), or a Licensed Practical Nurse (LPN). Respite services are limited to a maximum of 100 hours per Care Plan year. Nursing Respite services must not be provided by a member of the member's household or by any relative approved as the employed caregiver. Specific services may include the following;

1. SCOPE OF SERVICES

- A. Assistance with routine activities of daily living such as bathing, eating, meal preparation, dressing, and hygiene;
- B. Assistance with routine instrumental activities of daily living such as general housekeeping;
- C. Assistance with personal care services or private duty nursing services, based on the member's needs;
- D. Assistance with the enhancement of self-help skills; and

- E. Assistance with providing opportunities for leisure, play and other recreational activities.

2. SERVICE REQUIREMENTS

- A. Respite services are available to any member of any age.
- B. Respite services are determined by the MCO Care Coordinator and documented on the Care Plan.
- C. Respite services may be provided in the member's home, in the respite provider's home, and in the community.

3. AGENCY PROVIDER REQUIREMENTS

- A. The provider agency of Nursing Respite Services must meet all requirements, certifications and training standards set forth by the HSD/MAD to provide Private Duty Nursing services, as described in the Private Duty Nursing service standards.
- B. Refer to the appropriate program standards for Private Duty Nursing services for additional information on certification requirements, supervision requirements, services, and program standards for the provision of Private Duty Nursing Respite Services.
- C. Supervision of Nursing Respite Service employees must be documented by the Nursing respite supervisor. The supervisor must be a staff member of the nursing respite provider agency and provide in-service training to the personnel providing the care.
- D. Supervision of Nursing Respite Services will be done at least quarterly. A Registered Nurse must supervise Private Duty Nursing Respite employees. The supervisory nurse must be on the staff or a MCO of the provider agency to supervise and provide in-service training to the personnel providing the care.
- E. Nursing Respite service providers must maintain a current roster that is updated quarterly of Nurse Respite providers to provide services as requested by the member or family.
- F. Nursing Respite service providers must immediately notify the MCO Care Coordinator if there is a change in the member's condition, if the member refuses care or if the agency is unable to comply with the care delivery as agreed upon in the Care Plan.

4. AUTHORIZATION OF NURSING RESPITE CARE SERVICES

- A. Scheduling of hours for use of Nursing Respite Services will be the responsibility of the Nursing Respite Service Provider and the member.
- B. Nursing Respite services provided by the Private Duty Nursing provider require a physician's order that includes the scope and duration of service(s). A new physician's order will be obtained when there is a revision in the service, and/or on an annual basis with the Care Plan renewal. The order must be obtained by the agency providing PDN and shared with the MCO.
- C. The provider agency may require advanced notice from the member/family for provision of services and will notify members of their advanced notice requirement.
- D. The provider of Nursing Respite Services must maintain a cumulative record of utilization of respite care, to include time used.
- E. The member cannot schedule his or her own respite with the nursing respite staff.

- F. The member may receive a maximum of 100 hours annually per Care Plan year provided there is a primary caregiver.

5. REIMBURSEMENT

- A. Reimbursement is on an hourly unit rate and is accrued to the nearest quarter of an hour. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.
- B. Reimbursement for Nursing Respite services will be based on the current negotiated with the MCO the services. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

RESPITE SERVICES

Respite services provide the member's unpaid primary caregiver with a limited leave of absence to prevent burnout and provide temporary relief to meet a family crisis, emergency or caregiver's illness as determined in the Comprehensive Care Plan (CCP). An unpaid primary caregiver is the individual who has been identified in the CCP and who assists the member on a frequent basis, i.e. daily or at a minimum weekly. It is not necessary for the unpaid primary caregiver to reside with the member in order to receive respite services. Respite services may be provided in the member's home, in the respite provider's home and in the community. ~~RR~~ Respite services are limited to a maximum of 100 hours per CCP year. Respite services must not be provided by a member of the member's household or by any relative approved as the employed caregiver. Respite Services are provided to ABCB member s on an episodic basis that enables members to accomplish tasks that they would normally do for themselves if they did not have a disability. Respite services assist the members to maintain the home (or living area occupied by the participant) in a clean and safe environment and assist the member in activities of daily living (ADL). Respite services are provided pursuant to the CCP, developed and authorized by the recipient of service and the MCO Care Coordinator. Specific services may include the following:

1. SCOPE OF SERVICES

- A. Household Activities – The following household activities are considered necessary to maintain a clean and safe environment and to support the member's living in their home. These activities are limited to maintenance of the member's individual living area (i.e. kitchen, living room, bedroom, and bathroom). For example, the respite staff would not clean the entire home if the member only occupies three (3) rooms in a house of (6) rooms. In this case, the caregiver would clean the three rooms only. The respite services will assist the member in performing these activities independently or semi-independently when appropriate. These duties are performed as indicated in the CCP:
 - a. Sweeping, mopping or vacuuming of carpets, hardwood floors, or linoleum;
 - b. Dusting of furniture;
 - c. Changing of linens;
 - d. Doing laundry (member's clothing and linens only);
 - e. Cleaning bathrooms (tub and/or shower area, sink, and toilet);and/or

- f. Cleaning of kitchen and dining area after preparation and serving meals by the respite staff for member, such as washing dishes, putting dishes away; cleaning counter tops, dining table where the member ate, and sweeping the floor, etc.
- B. Meal Preparation – A tentative schedule for preparation of meals will be identified in the CCP as determined by the assessment. The respite staff will assist the member in independent or semi-independent meal preparation, including dietary restrictions per physician order.
- C. Personal Care – The CCP may include the following tasks to be performed by the respite service:
- a. Bathing – Giving a Sponge bath/Bed bath/Tub Bath/Shower, including transfer in/out;
 - b. Dressing – Putting on, fastening, removing clothing; including prosthesis;
 - c. Grooming – Shampooing, combing or brushing hair, applying make-up, trimming beard or mustache, braiding hair, shaving under arms or legs as requested by the member;
 - d. Oral care – Brushing teeth, cleaning dentures/partials (includes use of floss, swabs, or mouthwash). Members whose swallowing reflex is not intact, are an exception and may require specialized oral care beyond the scope of this service as identified by a physician’s order;
 - e. Nail care – Cleaning or filing to trim and or do cuticle care. Members with diabetes are an exception and may require specialized nail care beyond the scope of this service as identified by a physician’s order;
 - f. Perineal Care – Cleansing of the perineal area and changing of sanitary napkins;
 - g. Toileting – Transferring on/off toilet, bedside commode and/or bedpan; cleaning perinea area, changing adult briefs/pads, readjusting clothing;
 - h. Bowel Care – Evacuation and ostomy care, including irrigations, changing and cleaning of bags, and ostomy site skin care. Members requiring the assistance of bowel care must be determined medically stable by his or her physician, and are able to communicate their bowel care verbally or in writing. A physician must prescribe a bowel program for the member. A registered nurse is required to provide whatever additional training the respite staff needs to ensure the respite staff is competent to implement the member’s bowel program. The respite staff must demonstrate competency to the nurse that he or she is able to properly implement the bowel program according to the physician’s order(s);
 - i. Bladder Care – Elimination, catheter care, including the changing and cleaning of catheter bag. Members requiring the assistance of a bladder care must be determined medically stable by his or her physician, and are able to communicate their bladder care verbally or in writing. A physician must prescribe a bladder program for the member. A registered nurse is required to provide whatever additional training the homemaker staff needs to ensure the respite staff is competent to implement the member’s bladder program. The respite staff must demonstrate competency to the

nurse that he or she is able to properly implement the bladder program according to the physician's order(s).

- j. Mobility Assistance – Assistance in ambulation, transfer and toileting, Defined as follows:
- k. Ambulation – Moving around inside and/or outside the home or member's living area with or without assistive device(s) such as walkers, canes and wheelchairs;
- l. Transferring – Moving to/from one location/position to another with or without assistive device(s); and/or
- m. Toileting – Transferring on or off toilet.
- n. Skin Care – Observation of skin condition for maintaining good skin integrity and prevention of skin infection, irritation, ulceration or pressure sores.
- o. Assisting with Self-Administered Medication – Prompting and Reminding in accordance with the New Mexico Nursing Practice Act. Getting a glass of water or juice as requested if member is not able to do that for himself/herself, handing the member a daily medication box or medication bottle. For the nurse practice act, refer to the PDN service standards.
- p. Eating – Assistance with eating as determined in the Care Plan. Individuals requiring tube feeding or J-tube feedings or who are at risk for aspiration are an exception and require specialized care as prescribed by physician.
- q. Range of Motion Exercises as described in a Therapeutic Plan developed by therapists and taught to the caregiver and caregiver supervisor by a Physical Therapist or Occupational Therapist.
- r. Support Services – Support services provide additional assistance to members in order to promote independence and enhance his or her ability to remain in a clean and safe environment. The following support services will be identified in the assessment of the Instrumental Activities of Daily Living and are provided as determined in the Care Plan:
- s. Shopping and/or completing errands for the member, with or without the
- t. member; and
- u. Accompanying or assisting with non-medical transportation.

2. AGENCY PROVIDER REQUIREMENTS

The respite staff must possess a current New Mexico driver's license and a Motor vehicle insurance policy if the member is to be transported by the respite staff. Release of Liability Forms must be completed and on file in the member and/or employee's file. Respite provider agencies are not required to provide transportation services. The MCO Care Coordinator assess the member's formal and informal support system and determine if other individuals and/or other Medicaid agencies can provide assistance with shopping and transportation services.

A. Service Requirements

- a. Respite services are available to any member of any age.
- b. Respite services are determined by MCO Care Coordinator and documented on the CCP.

- c. Respite services may be provided in the member's home, in the respite provider's home, and in the community.
- B. Administrative Requirements:
 - a. Respite agencies may be licensed by the Department of Health (DOH) as a home health agency pursuant to 7.28.2.1 NMAC et seq.
 - b. Respite services may be provided by agencies approved by HSD/MAD.
 - c. Respite agencies must comply with DOH abuse registry screening laws regulations in accordance with the Department of Health Act, NMSA 1978, section 90706(E) and the Employee Abuse Registry Act, NMSA 1978, Sections 24-27-1 to 24-27-8.
 - d. Respite agencies must provide incident management and review on an annual basis. Maintain documentation in the employee's personnel file as required by HSD/MAD.
 - e. Respite agencies must comply with all requirements set forth in the Medicaid Provider Participation Agreement (MPPA).
 - f. Respite agencies must have available and maintain a roster of trained and qualified respite employee(s) for back-up or regular scheduling and emergencies. For members whose health and welfare will be at risk due to absence, there should be a back-up plan that ensures the member's health and safety.
 - g. Respite agencies must have available in the member's home a current copy of the CCP and any additional materials/instructions related to the member's care.
 - h. Training of the bowel & bladder care must be taught by a Registered Nurse with a current license to practice in the state of New Mexico. Upon completion the respite staff must demonstrate competencies to perform individualized bowel and bladder programs. No respite staff will provide bowel and bladder services prior to completion of the initial training.
 - i. Respite supervisors must provide specific instructions to assigned respite staff on each member prior to providing services to the member.
 - j. Respite agencies must ensure written notification to the MCO and provide the MCO with a copy of the incident report.

3. REIMBURSEMENT

Respite provider agencies must maintain appropriate record keeping of services provided personnel and training documentation, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for respite services will be based on the negotiated rate with the MCOs. Providers of respite services have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS OR EXCLUSIONS

- A. Respite services may not be provided to the member by his or her spouse.
- B. Respite services cannot be included in the CCP in combination with Assisted Living.

- C. Respite services are limited to a maximum of 100 hours annually per care plan year provided there is a primary caretaker. Additional hours may be requested if an eligible member's health and safety needs exceed the specified amount.
- D. ~~For children and youth up to 21 years of age diagnosed with a serious emotional or behavioral health disorder, respite services are limited to 720 hours a year or 30 calendar days.~~

5. AUTHORIZATION OF PERSONAL CARE RESPITE SERVICES

- a. Scheduling of hours for use of Respite Services will be the responsibility of the member of service or their representative.
- b. The provider agency may require advanced notice from the member/family for provision of services and will notify members of their advanced notice requirement.
- c. The provider of Respite Services must maintain a cumulative record of utilization of respite care, to include time used.
- d. The member cannot schedule his or her own respite with the respite staff.
- e. The member may receive a maximum of 100 hours annually per Care Plan year provided there is a primary caregiver.

6. OTHER

Under no circumstances may a respite staff act on behalf of a member as their representative in matters regarding medical treatment, financial, legal or budgetary decision-making, and/or manage a member's finances. An immediate referral must be made to the MCO in order to determine if the member should be referred to an appropriate social service or legal services agency(s) for assistance in these areas.

SKILLED MAINTENANCE THERAPIES

Skilled Maintenance Therapies include Occupational Therapy (OT), Physical Therapy (PT) and Speech and Language Therapy (SLT) for individuals twenty-one years and older. These services are an extension of therapy services provided for acute and temporary conditions that are provided with the expectation that the individual will improve significantly in a reasonable and generally predictable period of time. Skilled Maintenance Therapy services are provided to adults with a focus on maintenance, community integration, socialization and exercise, or enhance support and normalization of family relationships.

1. LIMITS OR EXCLUSIONS

A signed therapy referral for treatment must be obtained from the member's primary care physician. The referral will include frequency, estimated duration of therapy, and treatment/procedures to be rendered

OCCUPATIONAL THERAPY FOR ADULTS

Occupational therapy is a skilled therapy service for individuals 21 years and older provided by a licensed Occupational Therapist. Occupational Therapy services promote/maintain fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. A signed occupational therapy referral for treatment must be obtained from the member's primary care physician in accordance with state laws and applicable regulations. A copy of the written referral will be maintained in the member's file by the occupational therapist and shared with the MCO. Children (individuals under the age of 21 receive this service through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Specific services may include the following;

1. SCOPE OF SERVICES

- A. Teaching daily living skills;
- B. Developing perceptual motor skills and sensory integrative functioning;
- C. Designing, fabricating or modifying of assistive technology or adaptive devices;
- D. Providing assistive technology services;
- E. Designing, fabricating or applying of selected orthotic or prosthetic devices or selecting adaptive equipment;
- F. Using specifically designed crafts and exercise to enhance functional performance;
- G. Training regarding OT activities;
- H. Consulting or collaborating with other service providers or family members, as directed by the member; and/or
- I. Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up.

2. SERVICE REQUIREMENTS

- A. The occupational therapist must perform a comprehensive assessment evaluation for each member to determine appropriate therapy and coordinate services with the MCO care coordinator. Services may include the following:
 - a. Obtaining pertinent medical history.
 - b. Assessing of the member for specific needs in gross/fine motor skills pertinent to occupational therapy.
 - c. Adapting the member's environment in order to meet his/her needs.
 - d. Evaluating, administrating and interpreting tests.
 - e. Assessing, interpretation and summary of objective evaluation findings, identification of functional problems, and determining treatment goals that is objective and measurable with a statement on potential to achieve goals.
 - f. Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response.
 - g. Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation.
 - 1. Analyze and interpret member's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings. Identify short-and long-term goals that are measurable, objective, and related to functional mobility as determined by medical history and evaluative findings.
 - 2. Formulate a treatment plan to achieve the goals identified. The treatment plan should include frequency, estimated duration of therapy, treatment/procedures to be rendered, member's response to treatment, and progress toward therapy goals with dates and time of service.
 - 3. Review physician's request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings.
 - 4. Implement and administer appropriate treatment.
 - h. Providing the member or caregiver education and documenting in the member's medical record.

- i. Preparing Discharge Summary and include the number and types of treatment provided. The member disposition at discharge including functional, sensory/perceptual, and physical and status of all levels and follow-up recommendations as indicated.
- B. The staff: client rate is 1:1 for the period of time in which a specific member is receiving therapy services.
- C. Therapy services may be provided at:
 - a. A community based center, i.e. therapy center.
 - b. The member's home.
 - c. Any other location in which the member engages in day-to-day activities.
- D. Therapy services require face-to-face contact, except that non face-to-face consultation and individual-specific assistive technology development is allowable according to limits specified in the reimbursement section of these standards.

3. AGENCY PROVIDER REQUIREMENTS

- A. Staffing Requirements
 - a. Graduation from an accredited occupational therapy program and current licensure as required by New Mexico State law.
 - b. Must have a current licensure by state of New Mexico.
 - c. Occupational therapy experience preferably in home care and general acute care.
 - d. Must have access to all required diagnostic and therapeutic materials to provide services.
 - e. Must be proficient in the member's primary language or have access to an interpreter (family member, friend, or caregiver). Professional interpretation service fees are the responsibility of the agency.
 - f. Must be culturally sensitive to the needs and preferences of members and their households based upon language. Communicating in a language other than English may be required.
 - g. Certified Occupational Therapy Assistants (COTA) may perform Occupational therapy procedures and related tasks pursuant to a Plan of Care written by the supervising licensed occupational therapist. A COTA must be supervised by a licensed occupational therapist. All related tasks and procedures performed by a COTA must be within a COTA scope of service following all federal and state requirements applicable to COTA services.
- B. Administrative Requirements
 - a. Provider agencies must adhere to the HSD/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background check, Labor Laws, etc.
 - b. Provider agencies will establish and maintain financial reporting and accounting for each individual.
 - c. All services must be under the order of the member's Primary Care Physician. The order will be obtained by the Skilled Therapist, and shared with the Care Coordinator.
 - d. Therapy reports must be current and available upon request of HSD/MAD.

4. REIMBURSEMENT

Each provider of a service is responsible to provide clinical documentation that identifies his or her role in all components of the provision of home care, including assessment information, care planning, intervention, communications, care coordination, and evaluation. There must be justification in each member's clinical record supporting medical necessity for the care and for the level or intensity (frequency and duration) of the care. All services must be reflected on a Care Plan that is coordinated with the member/member representative, other caregivers as applicable, and authorized by the MCO. All services provided, claimed, and billed must have documented justification supporting medical necessity.

- A. Payment for occupational therapy services through the MCO is considered payment in full.
- B. Occupational Therapy services must abide by all federal, state, HSD policies and procedures regarding billable and non-billable items.
- C. Billable hours are as follows:
 - a. Face-to-face activities described in the Scope of Service.
 - b. Maximum of eight (8) hours for an initial comprehensive individual assessment.
 - c. Maximum of eight (8) hours to develop an initial comprehensive therapy plan.
 - 1. Attendance and/or telephone conference call to participate in interdisciplinary team meetings.
 - 2. Annual maximum of six (6) hours to complete progress reports and/or to revise annual plan.
 - 3. Annual maximum of eight (8) hours to arrange assistive technology development.
 - 4. Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour.
 - 5. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.
- D. The MCO does not consider the following to be professional occupational therapy services and will not authorize payment for the following non-billable activities:
 - a. Performing specific errands for the individual and/or family that are not program specific.
 - b. Friendly visiting.
 - c. Financial brokerage services, handling of member finances, or, preparation of legal documents.
 - d. Time spent on paperwork or travel that is administrative for the provider.
 - e. Transportation of members.
 - f. Pick up and/or delivery of commodities.
 - g. Other non-Medicaid reimbursable activities.
- E. Occupational therapy services are provided with the understanding that the MCO is the payer of last resort. Occupational therapy services should not be requested or authorized until all other third party and community resources have been explored and/or exhausted. If services are available for reimbursement through

third party liability or other payment sources, these sources must be accessed before ABCB services are delivered.

- F. Occupational therapy providers must ensure all insurance records are maintained correctly.
- G. Reimbursement for occupational therapy services will be based the negotiated rates with the MCO. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

PHYSICAL THERAPY FOR ADULTS

Physical therapy is a skilled therapy service for members 21 years and older provided by licensed Physical Therapist. Physical Therapy services promote/maintain gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. A signed physical therapy referral for treatment must be obtained from the member's primary care physician in accordance with state laws and applicable regulations. A copy of the written referral will be maintained in the member's file by the physical therapist and shared with the MCO Care Coordinator. (Individuals under the age of 21 receive this service through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Specific services may include the following;

1. SCOPE OF SERVICES

- A. Providing professional assessment(s) of the individual for specific needs in gross/fine motor skills;
- B. Developing, implementing, modifying and monitoring physical therapy treatments and interventions for the member;
- C. Designing, modifying or monitoring use of related environmental modifications;
- D. Designing, modifying and monitoring use of related activities supportive to the Care Plan goals and objectives;
- E. Consulting or collaborating with other service providers or family members, as directed by the participant;
- F. Using of equipment and technologies or any other aspect of the member's physical therapy services;
- G. Training regarding physical therapy activities;
- H. Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up.

2. SERVICE REQUIREMENTS

- A. The physical therapist must perform a comprehensive assessment evaluation for each member to determine appropriate therapy and coordinate services with the MCO Care Coordinator. Services may include the following:
 - a. Obtaining pertinent medical history.
 - b. Assessing of the member on physical strengths and deficits including, but limited to:
 - 1. Range of motion for all joints.
 - 2. Muscle strength, gait pattern, sensation, balance, coordination, and perception.
 - 3. Skin integrity and respiratory status.
 - c. Functional level of motor developmental level.
 - d. Adapting the member's environment in order to meet his/her needs.

- e. Evaluating, including the administration and interpreting tests and measurements within the scope of the practitioner;
 - f. Assessing interpretation and summary of objective evaluation findings, identification of functional problems, and determining treatment goals that are objective and measurable with a statement on potential to achieve goals.
 - g. Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response.
 - h. Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation.
 - i. Analyze and interpret member's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings.
 - j. Identify short-and long-term goals that are measurable, objective, and related to functional mobility as determined by medical history and evaluative findings. Formulate a treatment plan to achieve the goals identified. The treatment plan should include frequency, estimated duration of therapy, treatment/procedures to be rendered, member's response to treatment, and progress toward therapy goals with dates and time of service.
 - k. Review physician's request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings.
 - l. Implement and administer appropriate treatment.
 - m. Providing the member or caregiver education and documenting in the member's medical record.
 - n. Preparing Discharge Summary and include the number and types of treatment provided. The member disposition at discharge including functional mobility level and follow-up recommendations as indicated.
- B. The staff: client rate is 1:1 for the period of time in which a specific member is receiving therapy services.
- a. Therapy services may be provided at:
 - 1. A community based center, i.e. therapy center.
 - 2. The member's home.
 - 3. Any other location in which the member engages in day-to-day activities.
- C. Therapy services require face-to-face contact, except that non face-to-face consultation and individual-specific assistive technology development is allowable according to limits specified in the reimbursement section of these standards.

3. AGENCY PROVIDER REQUIREMENTS

A. Staffing Requirements

- a. Graduation from an accredited physical therapy program and current licensure as required by New Mexico State law.
 - i. Must have a current licensure by state of New Mexico.
 - ii. Physical therapy experience preferably in home care and general acute care.

- iii. Must have access to all required diagnostic and therapeutic materials to provide services.
- iv. Must be proficient in the member's primary language or have access to an interpreter (family member, friend, or caregiver). Professional interpretation service fees are the responsibility of the agency.
- v. Must be culturally sensitive to the needs and preferences of members and their households based upon language. Communicating in a language other than English may be required.
- vi. Certified Physical Therapy Assistants (PTA) may perform Physical therapy procedures and related tasks pursuant to a Plan of Care written by the supervising licensed physical therapist. A PTA must be supervised by a licensed physical therapist. All related tasks and procedures performed by a PTA must be within a PTA scope of service following all federal and state requirements applicable to PTA services.

B. Administrative Requirements

- a. Provider agencies must adhere to HSD/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background check, Labor Laws, etc.
- b. All services must be under the order of member's Primary Care Physician. The order will be obtained by the Skilled Therapist, and shared with the MCO Care Coordinator.
- c. Therapy reports must be current and available upon request of HSD/MAD.

4. REIMBURSEMENT

Each provider of the physical therapy service is responsible to provide clinical documentation that identifies his or her role in all components of the provision of physical therapy, including assessment information, care planning, intervention, communications, and evaluation. There must be justification in each member's clinical record supporting medical necessity for the physical therapy and for the level or intensity (frequency and duration) of the physical therapy service. All services provided, claimed, and billed must have documented justification supporting medical necessity.

A. Payment for physical therapy services through the MCO is considered payment in full.

B. Physical

- a. to complete progress reports and/or to revise annual plan.
- b. Annual maximum of eight (8) hours to arrange assistive technology development.
 - 1. Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour.
 - 2. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

C. The HSD/MAD does not consider the following to be professional physical therapy services and will not authorize payment for the following non-billable activities:

- a. Performing specific errands for the individual and/or family that are not program specific.
- b. Friendly visiting.
- D. Financial brokerage services, handling of member finances, or, preparation of legal documents. Therapy services must abide by all federal, state, HSD policies and procedures regarding billable and non-billable items.
- E. Billable hours are as follows:
 - a. Face-to-face activities described in the Scope of Service.
 - b. Maximum of eight (8) hours for an initial comprehensive individual assessment.
 - c. Maximum of eight (8) hours to develop an initial comprehensive therapy plan.
 - d. Attendance and/or telephone conference call to participate in interdisciplinary team meetings.
 - e. Annual maximum of six (6) hours
 - f. Time spent on paperwork or travel that is administrative for the provider.
 - g. Transportation of members.
 - h. Pick up and/or delivery of commodities.
 - i. Other non-Medicaid reimbursable activities.
- F. Physical therapy services are provided with the understanding that the MCO is the payer of last resort. ABCB services should not be requested or authorized until all other third party and community resources have been explored and/or exhausted. If services are available for reimbursement through third party liability or other payment sources, these sources must be accessed before ABCB services are delivered.
- G. Physical therapy providers must ensure all insurance records are maintained correctly.
- H. Reimbursement for physical therapy services will be based on the current negotiated rate with the MCO for the services. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

SPEECH THERAPY FOR ADULTS

Speech therapy is a skilled therapy service for individuals 21 years and older provided by a licensed speech and language pathologist. Speech Therapy services preserve abilities for independent function in communication; to facilitate oral motor and swallowing function, to facilitate use of assistive technology, and to prevent progressive disabilities. A signed speech therapy referral for treatment must be obtained from the member's primary care physician in accordance with state laws and applicable regulations. A copy of the written referral will be maintained in the member's file by the speech-language therapist and shared with the MCO Care Coordinator. Individuals under age 21 receive this service through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Specific services may include the following;

1. SCOPE OF SERVICES

- A. Identification of communicative or oropharyngeal disorders and delays in the development of communication skills.

- B. Prevention of communicative or oropharyngeal disorders and delays in the development of communication skills;
- C. Use of specifically designed equipment, tools, and exercises to enhance functional performance;
- D. Design, fabrication or modification of assistive technology or adaptive devices;
- E. Provision of assistive technology services;
- F. Evaluation, including administering and interpreting tests;
- G. Adapting the member's environment in order to meet his/her needs;
- H. Implementation of the maintenance therapy plan;
- I. Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up;
- J. Consulting or collaborating with other service providers or family members;
- K. Development of eating or swallowing plans and monitoring their effectiveness.

2. SERVICE REQUIREMENTS

- A. The speech-language therapist must perform a comprehensive assessment evaluation for each member to determine appropriate therapy and coordinate services with the MCO Care Coordinator. Services may include the following:
 - a. Obtaining pertinent medical history.
 - b. Assessing for speech-language disorders.
 - c. Assessing for swallowing disorders (dysphasia).
 - d. Assessing of communicative functions including underlying processes (i.e. cognitive skills, memory, attention, perception, and auditory processing, includes ability to convey or receive a message effectively and independently, regardless of the mode).
 - e. Assessing of oral motor function.
 - f. Assessing for the use of prosthetic/adaptive devices.
 - g. Assessing of resonance and nasal airflow.
 - h. Assessing of orofacial myofunctional patterns.
 - i. Assessing interpretation and summary of objective evaluation findings, identification of functional problems, and determining treatment goals that are objective and measurable with a statement on potential to achieve goals.
 - j. Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response.
 - k. Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation.
 - l. Analyze and interpret member's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings.
 - m. Identify short-and long-term goals that are measurable, objective, and related to augmentative/alternative communication and/or device treatment/orientation, orofacial myofunctional treatment, prosthetic/device treatment/orientation, swallowing function treatment, voice treatment, central auditory processing treatment, etc.
 - n. Formulate a treatment plan to achieve the goals identified. The treatment plan should include frequency, estimated duration of therapy,

treatment/procedures to be rendered, member's response to treatment, and progress toward therapy goals with dates and time of service.

- o. Review physician's request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings.
- p. Implement and administer appropriate treatment.
- q. Providing the member or caregiver education and documenting in the member's medical record.
- r. Preparing Discharge Summary and include the number and types of treatment provided. The member disposition at discharge including functional, sensory/perceptual, and physical and status of all levels and follow-up recommendations as indicated.
- s. The staff: client rate is 1:1 for the period of time in which a specific member is receiving therapy services.
- t. Therapy services may be provided at:
 - 1. A community based center, i.e. therapy center.
 - 2. The member's home.
 - 3. Any other location in which the member engages in day-to-day activities.

B. Therapy services require face-to-face contact, except that non face-to-face consultation and individual-specific assistive technology development is allowable according to limits specified in the reimbursement section of these standards.

3. AGENCY PROVIDER REQUIREMENTS

A. Staffing Requirements

- a. Graduation from an accredited masters or doctoral degree level, and holding the Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA).
- b. Must have a current licensure by state of New Mexico.
- c. Speech-language therapy experience preferably in home care and general acute care.
- d. Must have access to all required diagnostic and therapeutic materials to provide services.
- e. Must be proficient in the member's primary language or have access to an interpreter (family member, friend, or caregiver). Professional interpretation service fees are the responsibility of the agency.
- f. Must be culturally sensitive to the needs and preferences of members and their households based upon language. Communicating in a language other than English may be required.

B. Administrative Requirements

- a. Provider agencies must adhere to the HSD/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background check, Labor Laws, etc.
- b. Provider agencies will establish and maintain financial reporting and accounting for each individual.

- c. All services must be under the order of the member's Primary Care Physician. The order will be obtained by the Skilled Therapist, and shared with the MCO.
- d. Therapy reports must be current and available upon request of HSD/MAD.

4. REIMBURSEMENT

Each provider of a service is responsible to provide clinical documentation that identifies his or her role in all components of the provision of home care, including assessment information, care planning, intervention, communications, care coordination, and evaluation. There must be justification in each member's clinical record supporting medical necessity for the care and for the level or intensity (frequency and duration) of the care. All services must be reflected on a Care Plan that is coordinated with the member/member representative, other caregivers as applicable, and authorized by the MCO. All services provided, claimed, and billed must have documented justification supporting medical necessity.

- A. Payment for speech-language therapy services through the MCO is considered payment in full.
- B. Speech-Language Therapy services must abide by all federal, state, HSD policies and procedures regarding billable and non-billable items.
- C. Billable hours are as follows:
 - a. Face-to-face activities described in the Scope of Service.
 - b. Maximum of eight (8) hours for an initial comprehensive individual assessment.
 - c. Maximum of eight (8) hours to develop an initial comprehensive therapy plan.
 - d. Attendance and/or telephone conference call to participate in interdisciplinary team meetings.
 - e. Annual maximum of six (6) hours to complete progress reports and/or to revise annual plan.
 - f. Annual maximum of eight (8) hours to arrange assistive technology development.
 - g. Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour.
 - h. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.
- D. HSD/MAD does not consider the following to be professional speech language therapy services and will not authorize payment for the following non-billable activities:
 - a. Performing specific errands for the individual and/or family that are not program specific.
 - b. Friendly visiting.
 - c. Financial brokerage services, handling of member finances, or, preparation of legal documents.
 - d. Time spent on paperwork or travel that is administrative for the provider.
 - e. Transportation of members.
 - f. Pick up and/or delivery of commodities.
 - g. Other non-Medicaid reimbursable activities.

E. Speech-language therapy services are provided with the understanding that the MCO is the payer of last resort. ABCB services should not be requested or authorized until all other third party and community resources have been explored and/or exhausted. If services are available for reimbursement through third party liability or other payment sources, these sources must be accessed before ABCB services are delivered.

~~F.~~ Speech-language therapy providers must ensure all insurance records are maintained correctly.

~~G.~~ Reimbursement for speech-language therapy services will be based on the current negotiated rate with the MCO for the services. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

Agency Based Community Benefit

Services, Service Codes and Applicable Units of Service

SERVICE TYPE	CODE	UNIT INCREMENTS 1 UNIT =
Adult Day Health	S5100	15 minutes
Assisted Living	T2031	Month
Community Transition Services	T2038	Per service
Emergency Response	S5161	Month
Emergency Response High Need	S5161 U1	Month
Environmental Modifications	S5165	1 unit per project
Behavior Support Consultation	H2019	15 minutes
Behavior Support Consultation, Clinic Based	H2019TT	15 minutes
Employment Supports	H2024	Day
Home Health Aide	S9122	Hour
Personal Care-Consumer Directed	99509	Hour
Personal Care-Consumer Delegated	T1019	15 minutes
Personal Care under 21	S5125	15 minutes
Personal Care-Directed training	S5110	15 minutes
Personal Care-Directed-Administrative Fee	G9006	1 unit + 1 month
Private Duty Nursing for Adults – RN	T1002	15 minutes
Private Duty Nursing for Adults – LPN	T1003	15 minutes

Respite RN	T1002 U1	15 minutes
Private Duty Nursing for Adults – LPN	T1003 U1	15 min
Respite	99509 U1	Hour
Physical Therapy for Adults	G0151	15 minutes
Occupational Therapy for Adults	G0152	15 minutes
Speech Language Therapy for Adults	G0153	15 minutes