8. Agency-Based Community Benefits (ABCB)

8.1. General Information

The ABCB is intended to provide a community-based alternative to institutional care.

Members selecting the Agency Based model have the choice of the consumer delegated or consumer directed models for Personal Care Services (PCS).

- Home and Community Based Services (HCBS) shall meet all requirements of the HCBS Final Rule for Settings including the following requirements: Are integrated and support full access of Members 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;
- Are selected by the Member from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered care plan and are based on the Member's needs and preferences;
- Ensure a Member's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize, but do not regiment, Member's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
- Facilitate Member choice regarding services and supports, and who provides them.
  HCA will take the following factors into account when determining whether a setting may have the effect of isolating Members receiving Medicaid HCBS from the broader community of Members not receiving HCBS:
    - Due to the design or model of service provision in the setting, Members have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid funded HCBS. Opportunities as well as identified supports to provide access to and participation in the broader community, should be reflected in both the Member's person-centered care plans and policies and practices of the provider setting in accordance with 42 CFR 441.301(c)(1)(3) and (4)(vi)(F), 42 CFR 441.530(a)(1)(vi)(F) and 441.540, and 42 CFR 441.710(a)(1)(vi)(F) and 441.725;

- The setting restricts Member choice to receive services or to engage in activities outside of the setting; or
- The setting is physically located separate and apart from the broader community and does not facilitate Member opportunity to access the broader community and participate in community services, consistent with the Member's person-centered care plan.

8.2. Definitions

1. **Adult:** Individuals who are 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 (NOME).
3. **Annual:** The 12-month period covered by a Comprehensive Care Plan, except where otherwise stated.
4. **Adult Protective Services Division (APS):** APS Division of the Aging and Long Term Services Department.
5. **Care Coordinator (CC):** The individual responsible for coordinating a Member's services in the managed care program.
6. **Child:** An individual under 21 years of age.
7. **Community Re-integration:** Provides individuals the opportunity to move out of a Skilled Nursing Facility (SNF) into a community placement, after a 90-day continuous stay.
8. **Comprehensive Care Plan (CCP):** A comprehensive plan of services that meets the Member's physical, behavioral, and long-term needs.
9. **Consumer Delegated:** The consumer delegated model allows the Member to select their Personal Care Services (PCS) agency to perform all PCS employer-related tasks. This agency is responsible for ensuring all PCS are delivered to the Member.
10. **Consumer Directed:** The consumer-directed model allows the Member to oversee their own PCS delivery, and requires that the Member work with their PCS agency who then acts as a fiscal intermediary agency to process all financial paperwork to be submitted to the MCO.
11. **Electronic Visit Verification (EVV):** EVV is a computer-based system that electronically verifies the occurrence of authorized personal care service visits by electronically documenting the precise time and location where a service delivery visit begins and ends.
12. **Face-to-Face:** Being in the physical presence of the individual who is receiving services.
13. **Healthcare Authority (HCA):** Designated by CMS as the Medicaid administering agency in New Mexico.
14. **Home Delivered Medically Tailored Meals (MTM):** MTMs are fully prepared meals that are designed by a registered dietitian nutritionist (RDN) to meet the unique nutritional requirements of members with various health conditions. CB MTMs should incorporate local agriculture, local food vendors and local food preparation services to the extent practicable.

15. **Interdisciplinary Team (IDT):** IDT, consisting of the Member, the legal Authorized Representative (AR), the family, service providers and other people invited by the Member and the legal authority representative, if applicable.
16. **Immediate Family Member:** Father (includes natural or adoptive father, father-in-law, stepparent), mother (includes natural or adoptive mother, mother-in-law, stepparent), sibling (includes half sibling, stepsibling), child, stepchild, adoptive child, natural grandfather, natural grandmother, and spouse relationship to the individual.
17. **Incident Report:** Required form for documenting all reportable incidents of abuse, neglect, exploitation, death, expected and unexpected, environmental hazard, law enforcement intervention and emergency services.
18. **Legally Responsible Individual (LRI):** A person who has a duty under State law to care for another person. This category typically includes: the parent (biological or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or the spouse of a Member.
19. **Medical Assistance Division (MAD):** The MAD, New Mexico Healthcare Authority.
20. **Natural Supports:** Supports not paid for with Medicaid funds that assist the individual to attain the goals as identified on the Comprehensive 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.
21. **Nursing Facility Level of Care (NF LOC):** The Member's functional level is such that two or more ADL cannot be accomplished without consistent, ongoing, daily provision, of some or all of the following levels of service: skilled, intermediate or assisted. A Member must meet an NF LOC to be eligible for NF placement and CB services.
22. **Parent:** Natural or adoptive mother or father, or stepmother, stepfather.
23. **Person-Centered Care Plan (PCCP):** A procedural plan that describes the provision of specified activities and oversight on a routine basis in order to safeguard the health of the Member.
24. **Primary Caregiver:** The person who takes primary responsibility for someone who cannot carefully for themselves. The primary caregiver may be a family Member, a trained professional or another individual.
25. **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.

26. **Signature:** Signature of Member or Member's legal representative. If a Member is unable to sign and does not have a legal representative, a thumbprint or personal mark (i.e., an "X") will suffice. Wherever signature is required, verified electronic signature may be used.
27. **Verified Electronic Signature:** A verified electronic signature is an electronic signature that has been confirmed to be authentic and has not been tampered with. There are multiple ways to verify an electronic signature, including, but not limited to, Digital Certificates, Passwords, and Two-Factor Authentication. An agency may use their choice of authentication method, which must be outlined in the company's manual/training materials.

8.3. ABCB Services Requirements

These requirements apply to the services provided through the Medicaid 1115 Waiver for Members who meet the eligibility criteria for HCBS, ABCB. These requirements clarify, interpret, and further enforce 8.308.12 NMAC, *Managed Care Program*, *Community Benefit*.

- ABCB providers must meet all Federal requirements for HCBS providers, including the Final HCBS Settings Rule. All ABCB providers must be enrolled as an active Medicaid approved provider type 363 (Community Benefit Provider) and have HCA/MAD approval to provide that service. All incomplete applications submitted to the HCA/MAD Long-Term Services and Supports Bureau (LTSSB) shall be rejected and not considered for review until a complete application is submitted.

The requirements address each service covered by ABCB. Members served through this program will expect to receive services that meet these requirements. The MCO must document each member's choice of CB settings in the CCP. MCOs must contract with an active ABCB Medicaid approved provider type 363 that has approval from HCA/MAD to provide that service before rendering CBs to Members. Eligible ABCB providers are those that have been approved and certified by the HCA/MAD/LTSSB, per 8.308.2.9 NMAC *Managed Care Program, Provider Network*. Each MCO must ensure that it has an adequate statewide provider for all ABCB Services.

These requirements define the services offered as approved by CMS. The ABCB services are a supplement to the Member's natural supports and are not intended to replace family supports. ABCB is not a 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 their health and safety. The purpose of this program is to provide assistance to individuals that require LTSS so they may remain in the family residence, in their own home, or in community residences. This program serves as an alternative to placement in a Nursing Facility. The ABCB services are implemented in accordance with the Person-Centered Care Plan (PCCP) and/or Comprehensive Care Plan (CCP) as developed by the Member and the MCO Care Coordinator. The PCCP must revolve around the ABCB Member and reflect their chosen lifestyle, cultural, functional, and social needs for successful community living.

8.4. ABCB Covered Services

All ABCB services are subject to the approval of the MCO/UR. Below is a list of ABCB covered services for Members in ABCB, followed by detailed service descriptions:

- Adult Day Health;
- Assisted Living;
- Behavior Support Consultation;
- Community Transition Services;
- Emergency Response;
- Employment Supports;
- Environmental Modifications;
- Home Delivered Meals
- Home Health Aide;
- Nutritional Counseling;
- Personal Care – Consumer Directed;
- Personal Care – Consumer Delegated;
- Private Duty Nursing (PDN);
- Nursing Respite;
- Respite; and
- Skilled Maintenance Therapy Services.
    - Occupational Therapy for Adults
    - Physical Therapy for Adults
    - Speech Therapy for Adults

All ABCB providers are required to participate in an annual audit conducted by the MCOs. The review includes an assessment of each provider's compliance with the HCBS Settings Rule. Failure to respond to the MCO audit and/or correct identified issues may lead to provider termination from the CB program.

8.5. 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 Members as determined by the PCCP incorporated into

the CCP. Adult Day Health settings must be integrated and support full access of Members receiving Medicaid HCBS to the greater community, 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 or more hours per day on a regularly scheduled basis, for one or more days per week, by a licensed Adult Day Care Center, that offers health and social services to assist Members to achieve optimal functioning. 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 Care Center must be coordinated by the Adult Day Care provider. Adult Day Health Centers must be physically located in New Mexico.

PDN services and Skilled Maintenance Therapies (physical, occupational, and speech) may be provided in conjunction with Adult Day Health services, by the Adult Day Care provider or by another qualified provider. PDN and therapy services must be provided by licensed nurses and therapists. The PDN and Skilled Maintenance Therapies must be provided in a private setting at the facility.

Scope of Services/Requirements:

- The health, safety, and welfare of the Member must be the primary concern of all activities and services provided. Provider staff must supervise all activities. Activities provided by the Adult Day Care Center are included in the negotiated rate with the MCO and are not billed separately. Specific services may include the following:
  - Coordination of transportation to and from the Adult Day Care center;
  - Activities that promote personal growth;
  - Activities that enhance the Member's self-esteem by providing opportunities to learn new skills and adaptive behaviors;
  - Supervision of self-administrated medication as determined by the New Mexico Nurse Practice Act;
  - Activities that improve capacity for independent functioning;
  - Activities that provide for group interaction in social and instructional programs and therapeutic activities;
  - Personal Care Services (PCS);
  - Meals that do not constitute a "full nutritional regime" of three (3) meals per day;
  - Intergenerational experiences;

- Involvement in the greater community; and
- Providing access to community resources as needed.

- Activities shall be planned by the Member, family, caregivers, volunteers, staff and other interested individuals and groups. The provider must ensure safe and healthy conditions for activities inside or outside the facility.
- An IDT meeting for each Member will occur at least quarterly to review ongoing progress of direct services and activities. The PCCP will be adjusted as necessary to meet the needs of the Member at the quarterly meeting or at other times as needed. A PCCP will be developed with identified goals and measurable objectives. It will be attached to or incorporated into the CCP.
- All activities must be supervised by provider staff. Members must never be left unattended. Adult Day Care Center staff must be physically present with the Member(s) at all times.
- Activities must be designed to meet the needs of the Member and enhance the Member's self-esteem by providing opportunities to:
  - Learn new skills and adaptive behaviors;
  - Improve or maintain the capacity for independent functioning; and
  - Provide for group interaction in social and instruction programs and therapeutic activities.

Provider Requirements/Qualifications:

- Adult day health services may be provided by eligible adult day care agencies.
- Adult Day Care Centers must maintain (no gaps in licensure) a full permanent license by Department of Health (DOH) as an adult day care facility pursuant to 7 NMAC 13.2. 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. Provisional licenses will not be accepted.
- Adult Day Care Centers must comply with the provisions of Title II and III of the Americans with Disabilities Act (ADA) of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.).
- In order to be approved and certified by the HCASD/MAD/LTSSB Adult Day Care Centers must be operating with a permanent license. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- Adult Day Care Centers must comply with all applicable cities, county or state regulations governing transportation services, if providing transportation services to its Members.

- Adult Day Care Centers must comply with the HCA/MAD requirements including but not limited to: OSHA training requirements; incident management reporting; criminal background check (CBC); labor laws, etc.
- Adult Day Care Centers must make appropriate provisions to meet the needs of adults who require special services as indicated in the Member's Care Plans.
- The MCO will provide a copy of the CCP to the Adult Day Care Services Provider.
- A written Adult Day Health Services PCCP will include the assessment of the special needs, the interventions to meet those needs, and evaluation of the plan, with changes as needed. The PCCP will be provided to the MCO Care Coordinator and must be incorporated into the Member's CCP.
- The provider must be culturally sensitive to the needs and preferences of the Member. Communicating in a language other than English may be required.

Reimbursement

Billing is on an hourly basis and is accrued to the nearest quarter of an hour. Training on Member specific issues is reimbursable and included in the MCO negotiated hourly rate. 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 this service have the responsibility to review the prior authorizations issued from the MCO to ensure 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.

Limits or Exclusions

The Member must attend the Adult Day Care Center for a minimum of two hours per day for one or more days per week and the frequency (number of days per week) of attendance at the center must be included in the individual's PCCP and the CCP.

8.6. Assisted Living Facility (ALF)

Assisted living facilities offer residential services that provide a homelike environment which may be in a group setting with individualized services designed to respond to the Member's needs as identified by the Member, provider, and the Care Coordinator. A PCCP is developed with the Member that needs

services in the ALF and incorporated in the CCP. Assisted living services include assistance with Activities of Daily Living (ADLs) (i.e., ability to perform tasks that are essential for self-care, such as bathing, feeding oneself, dressing, toileting, and transferring) and assistance with Instrumental Activities of Daily Living (IADLs) (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- Residents must have the ability to control their own schedules and activities;
- Treating each Member with dignity and respect;
- Promoting the individuality of each Member;
- Allowing each Member choice in care and lifestyle;
- 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; and
- Providing safe community outings or activities that facilitate community inclusion.

Scope of Services/Requirements:

- Core services provide assistance to the Member in meeting a broad range of activities of daily living. Specific services may include the following:
  - Personal Hygiene;
  - Dressing;
  - Eating;
  - Socialization- residents may have visitors of their choice at any time;
  - Opportunities for individual and group interaction;
  - Housekeeping;
  - Laundry;
  - Transportation- :The ALF may provide transportation to members, and if ALF provided transportation is not available, the ALF must assist residents in arranging transportation as needed;

- Meal preparation and dining,- food must be available to residents at all times;
- 24-hour, on-site response capability to meet scheduled or unpredictable Member needs;
- Capacity to provide on-going supervision of the ABCB Member within a 24-hour period;
- Coordination of access to services not provided directly;
- Participation in the IDT meetings for development of the PCCP;
- Implementation of the PCCP to meet the Member's needs, evaluation for effectiveness, and adaptation as needs change;
- Services provided to a resident at an ALF are pursuant to the PCCP, developed by the Member, provider and the MCO Care Coordinator; and/or
- Other direct services (not listed above as core services) that provide assistance to the Member in meeting a broad range of ADLs. Direct services may be provided by the ALF or may be provided by another ABCB active, Medicaid approved type 363 provider with HCA/MAD approval to provide that service. These direct care providers must be identified on the Member's PCCP, that is separate from the CCP, and might include:
  - PDN services for Adults (see the Scope of Services/Requirements for PDN); and/or
  - Skilled Maintenance Therapies for Adults (see the Scope of Services/Requirements for Skilled Maintenance Therapies); and/or
  - Adult Day Health.

Provider Requirements/Qualifications:

- Assisted Living Services must be provided by an active, Medicaid approved provider type 363 Assisted Living Facility (ALF).
- ALF must maintain (no gaps in licensure) a full permanent license by Licensing and Certification Bureau, Division of Health Improvement/Department of Health. Provisional licenses will not be accepted.
- ALF must comply with the provisions of Title II and III of the ADA of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.).
- The ALF must be located in the State of New Mexico.
- In order to be approved and certified by the HCA/MAD/LTSSB, ALF must be holding and operating with a fully approved permanent license. All incomplete applications submitted to the

HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.

- Assisted Living providers must ensure that personnel providing direct services (directly employed by the ALF or through a contract for services) meet all requirements established by HCA/MAD for direct services such as, PDN, and skilled maintenance therapies (see Provider Requirements/Qualifications for each separate service).
- Assisted Living providers are required to maintain staffing ratios and patterns that will meet the Member's needs as identified in the PCCP and the CCP.
- Assisted Living providers will develop a PCCP for each Member based on the assessment of the needs of the Member and include strategies to meet those needs. The PCCP must be evaluated for effectiveness and revised as the needs of the Member change. The PCCP is separate and incorporated into the CCP.
- Assisted Living providers will develop a written agreement with each ABCB Member residing in their ALF. This agreement will detail all aspects of care to be provided including identified risk factors.. 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 and must be maintained in the Member's file with the MCO. The original is maintained in the Member's file at the assisted living residence.
- Members shall be afforded the same protections from eviction as all tenants under landlord law of state, county, city or other designated entity. This includes, but is not limited to, the resident's right to an eviction hearing in district or magistrate court.
    - If an ALF must terminate a lease or evict a resident at will, written notice must be provided to the resident. This notice must include the reasons for termination of the lease and allow the resident 30 calendar days before they must vacate.
    - If a resident has their lease terminated/evicted, their MCO Care Coordinator must work with them to find appropriate alternative housing/placement.
    -
- Assisted Living providers must meet all requirements set forth by the Licensing and Certification Bureau/Department of Health. This would include the definition of a homelike environment described below:

- Providers must meet the minimum, applicable qualifications set forth by the Licensing and Certification Bureau of the Department of Health and HCA/MAD, including but not limited to: labor/staffing rules and regulations; criminal background checks; employee abuse registry; incident management reporting; OSHA training requirements, etc.
- Definition of Homelike Environment: A homelike environment must possess the following structural features prior to the placement of the ABCB Member. Meeting these requirements is the financial responsibility of the Assisted Living provider:
    - 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;
    - 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;
    - 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;
    - Kitchens must be furnished with a sink, a refrigerator, at least a two-burner stove top or 1.5 cubic foot microwave oven;
    - Each unit must be equipped with an emergency response system;
    - Common living areas must be smoke free;
    - Floor plans must be submitted to the HCA/MAD along with the Medicaid Provider Participation Application or renewal; and
    - In addition, CMS requires residential settings located in the community to provide Members with the following:
        - All Members must be given the option to receive HCBS in more than one residential setting appropriate to their needs;

- Private or semiprivate 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. Members must have access to food storage or food pantry area at all times, including at night. Members must be allowed their choice of what to eat and when they eat.
- ; Private or semiprivate bathrooms that include provisions for privacy;
- Common living areas and shared common space for interaction between Members, their guests, and other residents;
- Members must have the freedom and support to control their own schedules regarding their day to day activities including having visitors of their own choosing at any time of day or night, and being allowed privacy when visiting, making phone calls at any time of day or night, and being allowed privacy when making or receiving call; and being in their home and in the community when they so choose;
- Members will be treated with respect, choose to wear their own clothing, have private space for their personal items, , choose how and when to spend their free time, have easy access to resources and activities of their choosing in the community.

- 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 only 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; and the setting is physically accessible to the Member.
- Any modification of the above conditions must be supported by a specific need and justified and documented in the PCCP to address the following:
  - Identify a specific and individualized assessed need;
  - Document the positive interventions and supports used prior to any modifications to the PCCP;

- Document less intrusive methods of meeting the need that have been tried but did not work;
- Include a clear description of the condition that is directly proportionate to the specific assessed need;
- Include regular collection and review of data to measure the ongoing effectiveness of the modification;
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- Include the informed consent of the Member; and
- Include an assurance that interventions and supports will cause no harm to the Member.

Reimbursement

Billing for Assisted Living services is based on a daily rate which includes core services such as personal care. Reimbursement for Assisted Living 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 ensure the information on the prior authorization for their services is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected. An ALF may not bill the MCO for services that the prior authorization does not cover.

Limits or Exclusions

Assisted Living services includes core services, such as, but not limited to: personal care, transportation and meal preparation. These services cannot be billed separately. ALF services include the following ABCB services:

- Personal care services ;
- Respite;
- Environmental Modifications; and
- Emergency Response.

The Assisted Living provider is responsible for all of these services in the ALF. Therefore, billing for these services in addition to the Assisted Living services would constitute duplication of services. Assisted

Living services require a prior authorization from a Turquoise Care MCO and will not be approved retroactively.

- Room and Board
  - The ABCB does not reimburse for room and board costs for the Member (such as rent, groceries, etc.);
  - Room and board rates billed to the ABCB Members must be reported to the HCA/MAD along with the Medicaid Provider Participation Agreement (PPA) 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 HCA/MAD when they occur;
  - The provider must comply with all state and Federal guidelines regarding the establishment of room and board rates to the ABCB services recipients; and
  - Training on Member specific issues is reimbursable and is included in the daily rate negotiated with the MCO.
- Non-Billable Activities
  - Assisted Living providers will not bill the MCO for Room and Board;
  - General training requirements are an administrative cost and are not billable; and

    The Provider will not bill when a Member is hospitalized or in an institutional care setting.

If an MCO decides to terminate its contract with an ALF, it must follow the approved process per Section 4.9 of the MCO contract with HCA and submit a transition plan to HCA for all impacted Members in accordance with the requirements in Section 2 of this manual. The MCO will collaborate with HCA, ALTSD and DOH staff to ensure a successful transition for all of its Members to another MCO, to another ALF or to the community. The MCO will provide documents to include the rationale for its decision to terminate the contract to the HCA upon request. HCA will notify the other MCOs of the termination. The MCO will work closely with the ALF to ensure that all authorization and claims issues are addressed.

When HCA is notified about the closure of an ALF, it will notify the MCOs of the closure and will request a census of impacted Members from each MCO in addition to the forms required in Section 2 of this manual. HCA will require ongoing weekly updates from each MCO on their progress with transitioning Members to other settings. Throughout the closure and transition process, the MCOs will collaborate

with HCA, ALTSD and DOH staff, including the ALTSD ombudsman. The MCOs will work closely with the ALF to ensure that all authorization and claims issues are addressed.

8.7. Behavior Support Consultation (BSC)

A Behavior Support Consultant is a licensed professional as specified by applicable State laws and standards. BSC services assist the Member and their family as well as the direct support professionals (DSP). BSC services for the Member include:

- Assessments;
- Evaluations;
- Treatments;
- Interventions; and
- 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.

Scope of Services/Requirements:

BSC services are initiated when the MCO Care Coordinator identifies and recommends the service be provided to the Member/Member's representative and/or family Member(s). The Care Coordinator is responsible for including recommended units of BSC services into the CCP. Strategies, support plans, goals and outcomes will be developed based on the identified strengths, concerns and priorities in the PCCP.

BSC services include:

- Providing assessments, evaluations, development of treatment plans and interventions, training, monitoring of the Member/Member representative, and planning modification as needed for therapeutic purposes within the professional scope of practice of the BSC;
- Designing, modifying and monitoring the use of related activities for the Member/Member representative and/or family Member(s) that is supportive of the PCCP;
- Training families and DSPs in relevant settings as needed for successful implementation of therapeutic activities, strategies, and treatments;
- Consulting with the IDT Member(s), guardians, family, or support staff;
- Consulting and collaborating with the Member's PCP and/or other therapists and/or medical personnel for the purposes of evaluation of the Member developing, modifying or monitoring BSC services for the Member;

- Observing the Member/Member representative in all relevant settings in order to monitor the Member's status as it relates to therapeutic goals or implementation of BSC services and professional recommendations; and
- Services may be provided in a clinic, home, or community setting.

Comprehensive Assessment Guidelines:

- The BSC must perform an initial comprehensive assessment for each Member to give the appropriate behavior support recommendations, taking into consideration the overall array of services received by the Member. A comprehensive assessment must be done at least annually and when clinically indicated.

Attendance at the IDT Meeting:

- The BSC is responsible for attending and participating, either in person or by conference call in IDT meetings convened for service planning;
- 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; and
- The BSC must document in the Member's clinical file the date, time, and any changes to strategies, support plans, and goals and objectives as a result of the IDT meeting.

- Discharge Planning Documentation Requirements Include:
  - Reason for discontinuing services (such as failure to participate, request from Member/Member representative, goal completion, and/or failure to progress);
  - Written discharge plan shall be provided to the Member/Member representative and the MCO Care Coordinator by the BSC;
  - Strategies developed with Member/Member representative that can support the maintenance of behavioral support activities;
  - Family and direct support professional training that is completed in accordance with the written discharge plan; and
  - Discharge summary is to be maintained in the Member's clinical file maintained by the BSC and a copy is to be sent to the MCO Care Coordinator and distributed to the Member/Member representative.

Other Documentation Requirements:

- Documentation must be completed in accordance with applicable HCA/MAD and Federal guidelines;
- All documents are identified by title of document, Member name, and date of documentation. Each entry will be signed with appropriate credential(s) and name of person making entry;
- Verified electronic signatures may be used. BSC name and credential(s) typed on a document is not acceptable;
- All documentation will be signed and dated by the BSC providing services;
- 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;
- BSC progress/summary notes will include date of service, beginning/end time of service, location of service, description of service provided, Member/family/DSP response to service, and plan for future service;
- 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;
- Any modifications that need to be included in the PCCP must be coordinated with the MCO Care Coordinator;
- Complications that delay, interrupt, or extend the duration of the program will be documented in the Member's medical record and in communications to the physician/health care provider as indicated;
- Each Member will have an individual clinical file maintained by the provider; and
- Review physician/health care provider orders at least annually and as appropriate and recommend revisions to the PCCP and CCP based on evaluation findings.

Agency Provider Requirements/Qualifications:

- BSC services must be provided by an active, Medicaid approved provider type 363 BSC provider.
- Employees of a provider agency who offer BSC services shall meet all the requirements under this section of the policy.

- The BSC agency must be able to demonstrate that all employees providing BSC, upon employment and thereafter, maintain (no gaps in licensure) a full permanent license through the appropriate board of licensure. Below identifies acceptable licensure for a BSC worker:
  - Master's degree from an accredited school for psychology, social work, counseling, or guidance program and maintain current permanent license as required by New Mexico State Law.
  - 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 Professional Clinical Counselor (LPCC).
    - New Mexico Licensed Marriage and Family Therapist (LMFT).
    - New Mexico Licensed Mental Health Counselor (LMHC).
- Maintain a culturally sensitive attentiveness to the needs and preferences of members and their families based upon culture and language. Communicating in a language other than English may be required.

Individual Provider Requirements/Qualifications:

- BSC services must be provided by an active, Medicaid approved provider type 363 BSC provider.
- An individual providing BSC services must maintain a full permanent license through DOH and shall meet all the requirements under this section of the policy. Provisional license is not acceptable.
- Must meet all other requirements listed under Agency Provider Qualifications/Requirements.

Reimbursement:

BSC providers are 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 PCCP

that is coordinated with the Member/Member's representative and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and authorized by the MCO.

Billing is on an hourly basis and is accrued to the nearest quarter hour. Training on Member specific issues is reimbursable and included in the negotiated rate. Payment for BSC services through the MCO is considered payment in full. Reimbursement for BSC services will be based on the MCO negotiated rate. BSC providers have the responsibility to review and ensure the information on the prior authorization for their services is current and correct. If the provider identifies an error, they will contact the MCO immediately to have the error corrected.

Limits or Exclusions

HCA/MAD does not consider the following to be professional BSC duties and will not authorize payment for:

- Performing specific errands for the Member/Member's representative or family that is not program specific;
- Friendly visiting;
- Financial brokerage services, handling of Member's finances or preparation of legal documents;
- Time spent on paperwork or travel that is administrative for the provider;
- Transportation of Member/Member's representative;
- Pick up and/or delivery of commodities; and
- Other non-Medicaid reimbursable activities.

8.8. Community Transition Services (CTS)

CTS are non-recurring set-up expenses for adults 21 years old and older who are transitioning from a SNF/NF to a living arrangement in the community where the person is directly responsible for their own on-going living expenses.

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

Allowable expenses are those necessary to enable a Member to establish a basic household. CTS are furnished only when the Member is unable to meet the expenses to initially establish their household or when the services cannot be obtained from other sources. CTS may not be used to furnish or establish living arrangements owned or leased by a service provider, except an ALF. Deposits to an ALF are limited

to $750.00. Services must be reasonable and necessary as determined by the MCO and authorized in the transition and/or discharge plan.

Scope of Services/Requirements:

CTS must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the discharge 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:

- 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;
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- Setup fees or deposits for utility or service access, including telephone, electricity, heating and water;
- Services necessary for the individual's health and safety such as but not limited to, pest eradication and one-time cleaning prior to occupancy;
- Moving expenses; and/or
- Fees to obtain a copy of birth certificate, identification card or driver's license.

The Community Transition Agency (CTA) must be able to provide at least two of the following core services:

  - Information and referral;
  - Independent living skills training;
  - Peer counseling; and
  - Individual and systems advocacy;

Provider Requirements/Qualifications:

The CTS may be provided directly by the MCO or contracted out to an active, Medicaid approved provider type 363 CTA. The CTA is defined as an agency that provides CTS to individuals who are transitioning from a SNF/NF to a home and community-based residence.

Reimbursement

Reimbursement for CTS will be based on the negotiated rate with the MCO. Training on Member specific issues is reimbursable and included in the negotiated rate, general training requirements are an administrative cost and are not billable.

CTS Providers have the responsibility to review the prior authorizations issued from the MCO to ensure that the information on the prior authorization for their services is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.

Limits or Exclusions

CTS 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. CTS are limited to $4,000.00 per person every five years. In order to be eligible for this service, the person must have an SNF/NF stay of at least 90 days prior to transition to the community.

The Care Coordinator must explain this service to the Member prior to discharge as part of the community reintegration process. The Member should request this service prior to discharging from the Nursing Facility. If the Member discharges from the NF to the community against medical advice (AMA) or without MCO acknowledgement, this benefit may not be available.

Payment for a deposit to an ALF is limited to $750.00.

8.9. Emergency Response Services (ERS)

(ERS) are provided through an electronic monitoring system to secure help in the event of an emergency. This service is to be used by ABCB members whose safety is at risk. The Member may use a portable “help” button to allow for mobility in the home environment. The monitoring system has a 24-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 service agency responds to alarm calls. (ERS) are provided pursuant to the CCP.

Scope of Services/Requirements:

Services provided by the emergency response service provider include:

- Installation, testing and maintenance of equipment;
- Training on the use of the equipment to members/caregivers and first responders;
- 24-hour monitoring for alarms;
- Monthly systems check, or more frequently if electrical outages, severe weather systems, etc. warrant more frequent checks;
- Reports of Member emergencies to the Care Coordinator and changes in the Member's condition that may affect service delivery;

- The response center must be staffed by trained professionals; and
- Emergency Response Service categories consist of emergency response, emergency response high need.

Provider Requirements/Qualifications:

- ERS services must be provided by an active, Medicaid approved provider type 363 ERS provider;
- In order to be approved and certified by the HCA/MAD/LTSSB, ERS providers must meet all provider requirements/qualifications under this section. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted;
- The ERS provider must have emergency monitoring capability 24 hours a day, seven days a week;
- The ERS provider must be able to demonstrate it has professional trained staff to answer and manage the response center;
- The ERS provider must be able to demonstrate it is:
    - Equipped to provide verifiable data using technology capable of producing a printed record of:
        - The type of alarm code (test, accidental or emergency);
        - The unit subscriber number;
        - The date; and
        - The time of the activated alarm in seconds.

  - Emergency Response Service providers must comply with all laws, rules and regulations of the New Mexico state corporation commission for telecommunications and security systems, if applicable.
- Provider agencies must establish and maintain financial reporting and accounting for each Member.
- 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.
- The provider agency will have security bonding.
- Emergency Response Service providers must report emergencies and changes in the Member's condition that may affect service delivery to the MCO Care Coordinator within 24 hours.
- 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 on a quarterly basis.
- Emergency Response service providers are not required to have an office located in New Mexico.

Reimbursement

- Reimbursement for (ERS) will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and ensure 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 monthly fee charged can be billed to the MCO for each calendar month the Member is authorized for use of the service.
- A fee for special equipment (e.g., a bracelet rather than a necklace) must be medically necessary and must be substantiated and authorized by the MCO. This is designated as Emergency Response High Need. The reason(s) for high need (ERS) must be documented in the CCP.
- All rates are based on the negotiated rate with the MCO.

Limits or Exclusions: None

8.10. 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 a Member 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 Member's CCP. 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 employment supports 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.

Scope of Services

Employment Supports facilitates competitive work in integrated work settings for individuals with disabilities (i.e., psychiatric, mental retardation, learning disabilities, and TBI) 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 and support full access of members 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 provide access to services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Employment Supports provides assistance such as job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision.

- Basic components of employment supports should seek to 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 employment supports used depend on the needs of the Member. The following are the basic components of employment supports:

- **Paid Employment** - Wages are a major outcome of employment supports. 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.
- **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 ensure it is a goal within their CCP. Members should not receive Employment Supports services through the ABCB program without first exhausting available vocational rehabilitation services. DVR services are considered unavailable if the Member is placed on the DVR waitlist.

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.

Provider Requirements/Qualifications:

- The employment supports services must be provided by an active, Medicaid approved provider type 363, Employment Supports provider;
- The employment supports provider must adhere to all rules and regulations regarding employment supports in this section of the policy and any applicable city, county or state regulations governing employment supports;
- The employment supports provider must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance;

- In order to be approved and certified by the HCA/MAD/LTSSB, Employment support providers must meet all requirements in this section of the policy. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted;
- Provider Records: The provider adheres to the Department of Labor wage laws and maintains required certificates and documentation. These documents are subject to review by the HCA/MAD. Each Member's earnings and benefits shall be monitored by the provider in accordance with the Fair Labor Standards Act. Each Member's earnings and benefits shall be reviewed at least semi-annually by the Employment Supports provider to ensure the appropriateness of pay rates and benefits;
- The Provider shall maintain a confidential case file for each Member and will include the following items:
  - Quarterly progress reports;
  - Vocational assessment or profile; and
    - Vocational assessments 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 acceptable to the Division of Vocational Rehabilitation (DVR) or HCA/MAD;
  - Career development plan as incorporated in the Comprehensive 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.

Provider Reporting Requirements/Qualifications:

The Employment Supports provider shall submit the following to the MCO Care Coordinator;

- Quarterly Progress Reports based upon the Care Plan cycle;
- Vocational Assessment; and
- Written updates, at least every six months, to the Work/Learn Action Plan.

Training Requirements

Providers shall retain staff trained to establish Career Development Plans. Training will be provided by the provider necessary to ensure that employees are able to demonstrate competency in skills listed under this policy.

- Staffing Requirements (Individual to Staff Ratio)

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 Member's needs and outcomes as indicated in the CCP and may vary according to purpose (e.g., job development, job training, job stabilization, career enhancement). For Employment Supports, the staff to individual ratio is 1:1 unless otherwise specified in the CCP. For Individual Employment Supports, a minimum of 1 one-hour face-to-face visit per month is required.

Staffing Requirements and Restrictions

Providers may not employ or sub-contract direct care personnel who are an immediate family Member of the Member served to work in the setting in which the Member is served.

- Qualification and Competencies for Employment Supports Staff: Qualifications and competencies for staff providing job coaching/consultation services shall, at a minimum, be able to:
  - Provide supports to the Member as contained in the work/learn action plan and incorporated into the CCP to achieve their outcomes and goals;
  - Employ job-coaching techniques and to help the Member learn to accomplish job tasks to the employer's specifications;
  - Increase the Member's capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;
  - Identify and strengthen natural supports that are available to the Member at the job site and fade paid supports in response to increased natural supports;
  - Identify specific information about the Member's interests, preferences and abilities;
  - Effectively communicate with the employer about how to support the Member to succeed in their employment, including any special precautions and considerations of the Member's disability, medications, or other special concerns;
  - Monitor and evaluate the effectiveness of the service and provide documentation that demonstrates this information was effectively communicated to the MCO Care Coordinator and the IDT members through progress notes, quarterly reports, and participation in IDT meetings;

- Address behavioral, medical or other significant needs identified in the work/learn action plan/CCP that require intensive one-on-one staff support;
- Communicate effectively with the Member including communication through the use of adaptive equipment if applicable, at the work site;
- Document information that pertains to the CCP, progress notes, outcomes, and health and safety issues/concerns and any and all other required documentation by HCA/MAD;
- Adhere to relevant state policies/standards and provider policies and procedures that directly impact services to the Member;
- Model behavior, instruct and monitor any workplace requirements to the Member;
- Adhere to professionally acceptable business attire and appearance, and interact and communicate through a business-like, respectful manner; and
- Adherence to the rules of the specific workplace, including dress, confidentiality, safety rules, and other areas required by the employer.

Supervision

- In a group employment setting (a setting where up to six individuals work in an integrated setting with staff supports on site), the Employment Supports provider determines the job site and is responsible for the day-to-day supervision of the members and for follow-up services. For individual placements, the employer is responsible for the provision of general supervision consistent with the role as employer. When necessary and appropriate, the Employment Support provider may supplement these services.

Reimbursement

Employment Supports providers must maintain appropriate record keeping of services provided, personnel and training documentation, and fiscal accountability as indicated in the Medicaid PPA. Billing is on an hourly basis 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 ensure 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.

Limits or Exclusions

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

8.11. 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.

Scope of Services

Environmental modifications are physical adaptations and environmental control systems excluding DME. Environmental modifications need to be identified in the Member's CCP. 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 exclude such things as carpeting, roof repair, furnace replacement, air conditioning, remodeling bare rooms, and other general household repairs.

Provider Requirements/Qualifications:

- The environmental modifications must be provided by an active, Medicaid approved provider type 363, environmental modifications provider.
- The environmental modification provider must comply with all New Mexico State laws, rules and regulations, including applicable building codes and the Construction Industries Licensing Act, NMSA 1978, Section 60-13-3.
- The environmental modification provider must maintain a 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.
- The environmental modification provider must provide a one-year warranty from the completion date on all parts and labor. 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.
- The environmental modification provider must ensure proper design criteria as addressed in planning and design of the adaptation. The environmental modification provider is responsible for all adaptions being made to Member's home, including but not limited to: oversight of construction and all administrative and technical oversight of projects.
- The environmental modification provider must provide consultation to family members, waiver providers and MCOs concerning environmental modification projects to the Member's residence and complete a final inspection of the environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation. The MCO Care Coordinator will also complete a final inspection to ensure the environmental modification provider has completed the project according to authorization before final payment is made to the environmental modification provider.
- Environmental modification providers who receive authorization from an MCO for a Member project must complete the authorized job and retain full control of the authorized project. Portions of the authorized project may be contracted out; however, the environmental modification provider retains full responsibility for the entire project.
- The environmental modification provider must establish and maintain financial reporting and accounting for each Member.

- The environmental modification provider will submit the following information and documentation to the MCO:
  - Environmental modification evaluation;
  - 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);
  - Letter of Acceptance of service cost estimate signed by the Member;
  - 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;
  - 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;
  - Documentation demonstrating compliance with the ADA.

- The Provider must submit the following to the MCO Care Coordinator, after the completion of work:
  - Letter of approval of work completed signed by the Member; and
  - Photographs of the completed modifications.
- The MCO must submit the Care Coordinator Individual Assessment of Need to the provider.

Reimbursement

Environmental modification provider agencies must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid PPA. Billing is based on a project basis, one unit per environmental modification project. Reimbursement for environmental modification services will be based on the authorized environmental modification project with the MCOs. Providers of service have the responsibility to review and ensure 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.

Limits or Exclusions

Environmental modification services are limited to $6,000.00 every five years. Administrative Costs of the provider for environmental modification services will not exceed 15% of the total cost of the environmental modification project for each project managed by the MCO.

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.

This service cannot be used to fund new construction including apartment buildings and Assisted Living facilities.

8.12. Home Delivered Meals

Medically Tailored Meals (MTM), provided for Agency Based Community Benefit members living in the community, up to two meals per day, provided as specified in the comprehensive care plan. Meals are medically tailored and based on the member's preferences.

Scope of Services/Requirements:

Turquoise Care members in Care Coordination Level 2 (CCL2) who meet a Nursing Facility Level of Care (NF LOC) and receive Agency-Based Community Benefit (ABCB) services may be eligible based on their comprehensive needs assessment (CNA).

Provider Requirements:

- Must be enrolled in New Mexico Medicaid as Provider Type 363 Community Benefit with specialty type 330.
- Must have knowledge of principles, methods, and procedures of the covered nutrition interventions meant to support an individual in obtaining food security and meeting their nutritional needs.
- Must be able to receive referrals from Turquoise Care MCOs.
- Must be able to deliver to the member's residence or other appropriate location, including last mile delivery, and track and report on service delivery (including unsuccessful deliveries).
- Must comply, during all stages of food service operation, with applicable federal, state and local regulations, codes, and licensor requirements relating to fire; health; sanitation; safety; building and other provisions relating to the public health, safety, and welfare of individuals receiving CB MTMs.
- Must follow best practice guidelines and industry standards for food safety. This includes meals remaining at safe temperatures, hot or cold, during transit and delivery.
- Must include a Registered Dietician or Registered Dietician Nutritionist or other comparable professional to develop the nutritional content of the CB MTMs.

- Must ensure that any employee or volunteer who delivers CB MTMs to a member's home has passed a background check, or the provider must use a delivery service such as U.S. Mail.
- Must not solicit payment or donations from any Medicaid member or their families/representatives.
- The provider will survey/connect with members on regular intervals to ensure quality of food and address any concerns.
- Meals must be medically tailored to a variety of diets and member preferences; however, the provider is not required to cater to all preferences and diets.
- Offering meals which cater to cultural and religious preferences are preferred but not required.

Billing and Reimbursement:

Procedure Code: CB Providers with provider type 363 and specialty type 330 will bill procedure code S5170.

Units: One meal is one unit. Two units are allowed per day.

Reimbursement: MCOs should reimburse providers at a minimum of $8.00 per home delivered meal.

Covered Services and limitations:

- Medically tailored home delivered meals are provided on a regularly scheduled basis, for one or more days per week, or as specified in the comprehensive care plan (CCP), in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the member. Services are furnished consistent with the member's person-centered care plan.
- Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).
- The receipt of MTM may reduce, but not replace, needed Personal Care Hours allotted for meal preparation. For example, MCOs must allow time for defrosting and heating meals as needed to ensure that members are able to consume CB MTMs.
- MTMs are not provided to CB members who reside in a licensed assisted living facility (ALF) or other location where a full nutritional regimen is provided.
- MTMs may be provided to members who receive adult day health (ADH) services, if MTMs are not provided at the licensed ADH facility.

- MTMs may not be provided if the member already receives full medically tailored nutritional support from another program.

Managed Care Organization Requirements:

- As with other CB services, MCOs must develop provider training and contracting information and provide network support for CB MTM providers.
- CB MTM providers will be audited annually with other CB providers.
- MCOs must develop and widely disseminate information to members and community stakeholders regarding access to the CB MTM benefit.
- MCOs must collaborate with Community Based Organizations (CBOs) to develop infrastructure that will eliminate barriers to becoming a CB MTM provider and to increase utilization of regional vendors and food producers.
- MCOs must implement oversight, monitoring and measures to ensure that CB MTMs are meeting generally accepted dietary guidelines for the member's condition(s).
- MCOs will ensure that care coordinators are trained to discuss CB MTMs with members by using, at a minimum, the following questions to prompt conversation. MCOs may develop additional questions as needed:
    1. Do you ever find yourself without enough money to buy the food you need, or face challenges in accessing healthy food due to factors such as availability or transportation?
    2. Do you have any dental, oral, or other medical conditions that make eating or swallowing difficult?
    3. Has a healthcare professional recommended that you change your diet due to a condition or illness, leaving you unsure about which foods are considered healthy?
    4. Do physical limitations make it challenging for you to prepare and consume healthy meals, shop for groceries, cook, or feed yourself?
    5. Have you had any unintended weight loss in the past 6 months?
    6. Are you able to store frozen or refrigerated meals until you are ready to eat them?
- MCOs will ensure member education includes:
    - Delivery method for receipt of meals,
    - Number of meals member will receive in each delivery and how many days/meals each delivery will cover,

- How to appropriately store meals, including how quickly meals must be stored once received, and space needed for storage,
- Member will need to make arrangements for any assistance needed in lifting meals box or putting meals away once received,
- Understanding how to contact the meal provider if any issues arise and how meal provider might contact member.

8.13. Home Health Aide (HH Aide)

HH Aide services provide total care or assist an eligible Member in all ADLs. 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.

Scope of Services/Requirements:

The HH Aide services assist the eligible Member in a manner that promotes an improved quality of life and a safe environment for the eligible Member. HH Aide services can be provided outside the eligible Member's home. State Plan HH Aide services are intermittent and provided primarily on a short-term basis; whereas, HH Aide services within the ABCB are provided hourly, for eligible ABCB members who need this service on a long-term basis. HH Aides may provide basic noninvasive nursing assistant skills within the scope of their practice. HH Aides perform procedures as an extension of nursing and therapy services such as; bowel and bladder care, ostomy site care, personal care, walking 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. HH aide services must be provided under the supervision of an RN 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.

All supervisory visits/contacts must be documented in the Member’s HH Aide clinical file on a standardized form that reflects the following:

- Service received;
- Member’s status;
- Contact with family members; and

- Review of HH Aide PCCP with appropriate modification annually and as needed.

Provider Requirements/Qualifications:

- HH Aide services must be provided by an active, Medicaid approved provider type 363, Home Health Agency (HHA);
- The HHA must maintain (no gaps in license) full permanent license by the New Mexico Licensing and Certification Bureau, Division of Health Improvement; DOH as an HHA;
- In order to be approved and certified by the HCA/MAD/LTSSB, the HHA must be holding and operating with a fully approved permanent license. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete packet is submitted;
- The HHA provider must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance.
- The HHA nursing supervisor(s) must have at least one year of supervisory experience. The nursing supervisor will supervise the RN, LPN and HH Aide;
- The HHA staff will be culturally sensitive to the needs and preferences of members and households. Arrangement of written or spoken communication in another language may need to be considered;
- The HHA will document and report any noncompliance with the CCP to the MCO Care Coordinator;
- All physician orders that change the Member's service needs must be conveyed to the MCO Care Coordinator for coordination with service providers and modification to CCP if necessary;
    - The HHA will document in the Member's clinical file that the supervision of the HH Aide occurs at least once every two weeks. Supervisory forms must be developed and implemented specifically for this task;
    - The HHA and MCO Care Coordinator must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care;
    - The HHA nursing supervisor, direct care RN and LPN shall train families, DSP 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; and

- It is expected the HHA will consult with IDT members, guardians, family, and DSPs as needed.

- **Qualifications for employed HH Aides:**
  - 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;
  - HH Aide training at the licensed HHA which follows the Federal HH Aide training regulation in 42 CFR 484.36 or the State Regulation 7 NMAC 28.2;
  - A CNA must have successfully completed the employing HH Agency's written and practical competency standards and have met the qualifications for a HH Aide. Documentation will be maintained in personnel file;
  - A HH Aide who was not trained at the employing HHA must successfully complete the employing HHA's written and practical competency standards before providing direct care services to an ABCB Member. Documentation will be maintained in personnel file; or
  - The HH Aide will be supervised by the HH Agency nursing supervisor or designee at least once every two weeks in the Member's home; and
  - The HH Aide will be culturally sensitive to the needs and preferences of the members and their families. Based upon the individual language needs or preferences, the HH Aide may be requested to communicate in a language other than English.

Reimbursement

The HHA must maintain appropriate record keeping of services provided by personnel and training documentation, and fiscal accountability as indicated in the Medicaid PPA. Billing is on an hourly basis and is accrued and rounded to the nearest quarter of an hour. Reimbursement for HH Aide services will be based on the negotiated rate with the MCOs. HHAs have the responsibility to review and ensure 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.

8.14. Nutritional Counseling

Nutritional Counseling services are designed to meet the unique food and nutritional needs of ABCB members. These services are available to assist members living in a community setting to maintain (or

improve and maintain) their health and/or functional status and remain in their setting of choice. This does not include oral--motor skill development services, such as those provided by a speech pathologist. Nutritional assessment is defined as the evaluation of the nutritional needs of the ABCB Member based upon appropriate biochemical, anthropometric, physical and dietary data to determine nutrient needs and includes recommending appropriate nutritional intake.

Nutritional counseling is defined as advising and helping an ABCB Member obtain appropriate nutritional intake by integrating information from the nutritional assessment with information on food, other sources of nutrients, and meal preparation consistent with cultural background and socioeconomic status.

Nutritional Counseling services may be in addition to and cannot duplicate nutritional or dietary services allowed in the Member's Medicaid state plan benefit, or another funding source.

Scope of Services/Requirements:

Services can be initiated where they are indicated and authorized in the Member's PCCP/CCP. A PCCP will be developed by the Nutritional Counseling provider with identified goals and measurable objectives and will be attached to or incorporated into the CCP. The MCO should agree to the arrangements for record-keeping, and the frequency and duration of services with the provider agency or individual provider.

Nutritional Counseling services include:

- Assessment of nutritional needs;
- Development and/or revision of the Member's nutritional plan; and
- Counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.

The services allow for consultation with appropriate professionals, attendance at/participation in Interdisciplinary Team meetings, liaison with the Member's representative/family/caregivers, and monitoring of the nutritional plan.

Services are person-centered and must be culturally sensitive to the needs and preferences of the Member and their household based upon language and cultural traditions.

The staff: client ratio is 1:1 with the Member and/or the Member's representative for the period of time in which the Member is receiving Nutritional Counseling services. All services should be provided face-to-face. They may be provided at the Member's residence or an appropriate community location.

Agency Provider Requirements/Qualifications:

- Nutritional counseling services must be provided by an active, Medicaid approved provider type 363 Nutritional Counseling provider.
- The agency must have on staff or employ a full-time licensed dietitian or a licensed nutritionist who maintains (no gaps in licensure) a full permanent license through the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq. Provisional permits are not acceptable.
- In order to be approved and certified by the HCA/MAD/LTSSB, Nutritional Counseling providers must be operating with a fully approved permanent license. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- Licensed nutrition associates will work under the supervision of a licensed dietitian or licensed nutritionist. The provider agency must ensure that the supervision requirements for licensed nutrition associates specified in the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq. are met.
- All licensed practitioners providing nutritional assessment and counseling services will operate within their professional scope of practice.
- Provider agencies must comply with the HCA/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background checks, Labor Laws, etc.
- Provider personnel 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.
- Provider agencies must employ and maintain a sufficient pool of appropriately licensed and trained personnel to provide scheduled services to all ABCB members.

Individual Provider Requirements/Qualifications:

- Nutritional counseling services must be provided by an active, eligible, Medicaid approved provider type 363 Nutritional Counseling provider.

- The individual must maintain a full permanent dietitian license or a nutritionist license (no gaps in licensure) through the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq. Provisional licenses are not acceptable.
- The individual may employ licensed nutrition associates who work under their supervision as a licensed dietitian or licensed nutritionist. The provider must ensure that the supervision requirements for licensed nutrition associates specified in the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et.seq. are met.
- All licensed practitioners providing nutritional assessment and counseling services will operate within their professional scope of practice.
- The individual provider must comply with HCA/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background checks, Labor Laws, etc.
- All personnel 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.
- The individual provider must employ and maintain a sufficient pool of appropriately licensed and trained personnel, sufficient to provide scheduled services to all ABCB members on their caseload.
- Nutritional Counseling services must abide by all federal, state, HCA policies and procedures regarding billable and non-billable items.

Reimbursement

Nutritional Counseling provider agencies and individual providers must maintain appropriate record-keeping of services provided, personnel and training documentation, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (PPA). All services must be reflected on a PCCP that is coordinated by the Care Coordinator and authorized by the MCO. Reimbursement for Nutritional Counseling services will be based on the negotiated rate with the MCO. Billing is on an hourly basis and is accrued and rounded to the nearest quarter of an hour. Payment for Nutritional

Counseling services through the MCO is considered payment in full. Providers of service have the responsibility to review the prior authorizations issued from the MCO to ensure that the information on the prior authorization for their service is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.

Billable Nutritional Counseling services include:

- Attendance and/or telephone conference calls to participate in Interdisciplinary Team meetings; and
- Training on Member-specific issues is included in the negotiated rate.

Limits or Exclusions

HCA does not consider the following to be Nutritional Counseling services and will not authorize payment for the following non-billable activities:

- General training requirements are an administrative cost and not billable;
- Performing specific errands for the individual and/or family that are not program specific;
- Friendly visiting**;**
- Financial brokerage services, handling of Member finances, or, preparation of legal documents;
- Time spent on paperwork or travel that is administrative for the provider;
- Transportation of members;
- Pick up and/or delivery of commodities; and
- Other non-Medicaid reimbursable activities.

Nutritional Counseling 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 Community Benefit services are delivered.

8.15. Personal Care Services (PCS)

Scope of Services

PCS have been established by HCA/MAD or Medicaid to assist individuals 21 years of age or older who are eligible for full Medicaid coverage and meet the NF 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 IADLs.

- The MCO determines medical LOC for PCS eligibility upon initial application and at least annually thereafter. Medicaid-eligible individuals may contact the MCO to apply for PCS.
- 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.
- PCS is a Medicaid service, not a Medicaid category of assistance, and services are delivered pursuant to an Individual Plan of Care (IPoC). PCS includes 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 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.
- PCS providers will use the HCA approved EVV system to record date and time for provided PCS. PCS agencies are responsible for establishing employment policies and providing oversight of employees to ensure the required use of EVV as mandated in the 21st Century Cures Act. Approved PCS providers will complete the required EVV system training within 30 days of contracting with the MCOs.

Members who wish to receive fewer PCS hours than initially authorized should inform their PCS provider and Care Coordinator. The Member and Care Coordinator will work together to determine if reducing hours is reasonable. If so, the Member will sign a new Community Benefit Member Agreement (CBMA) and can collaboratively revise the Member's Individual Plan of Care (IPoC) to reflect this reduced hour commitment. The request for a reduction in hours must be Member-driven. Reduction in hours should

not be considered if reduction request is due to provider agency inability to staff, provider agency or caregiver coercion, or due to dereliction of duties/ poor performance of the caregiver. Members must be informed of their right to request a new or additional caregiver or new provider when available. A Member's request for a reduction in hours should not be made for temporary or otherwise short-term periods. A Member must understand the request for reduced hours will be for the remainder of their budget/care plan year. However, if the Member has a change in condition, change to natural supports, or otherwise needs to increase their hours back to the original assessed number, they may work with their Care Coordinator to do so. Any reduction of underutilization of PCS hours shall not be used as justification to reduce any future assessment of services needed by the Member.

Eligible Population

To be eligible for PCS, a Member must meet all of the following criteria:

- Be a recipient of a full benefit Medicaid category of assistance and, not be receiving other Medicaid HCBS waiver benefits, Medicaid NF, ICF/IID Medicaid, PACE, or APS attendant care program, at the time PCS are furnished; an individual residing in an 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;
- Be age 21 or older;
- Be determined to have met NF LOC by the MCO; and
- Comply with all Medicaid and PCS regulations and procedures.

LOC Determination

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

- 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.

- Any individual applying for PCS who has an existing approved NF LOC determination in another program (i.e., NF) will not need an additional LOC determination until the next annual assessment.
- 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.
- 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 HCA pursuant to 8.352.2 NMAC, Recipient Hearings.
- 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.

Service Delivery Models – Consumer-Delegated PCS and Consumer-Directed PCS

- 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, 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.
    - 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.
    - The consumer-directed model allows the consumer to oversee their own service care delivery and requires that the consumer work with a PCS agency acting as a fiscal intermediary agency to process all financial and taxes paperwork.. Under this model, the agency acting as a fiscal intermediary can bill for a monthly administrative fee.

Consumer's Responsibilities

Consumers receiving PCS have certain responsibilities depending on the service delivery model they choose.

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

- Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;
- Allowing the PCS provider to complete monthly home supervisory visits;
- 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;
- 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
- Complying with all Medicaid rules, regulations, and PC service requirements; failure to comply may result in discontinuation of PCS.

- The consumer's or legal representative's responsibilities under the consumer directed model include:
  - Interviewing, hiring, training, terminating, and scheduling personal care attendants; this includes, but is not limited to:
    - Verifying 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 identification is kept in the attendant's personnel file at all times;
    - Verifying 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;
    - Identifying training needs; this includes training their own attendant(s) or arranging for training for the attendant(s);
  - 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;
  - Verifying services have been rendered by completing, dating, signing, and submitting documentation to the agency for payroll; a consumer or their legal representative is responsible

for ensuring the submission of accurate timesheets/logs; payment shall not be issued without appropriate documentation;

- Notifying the agency, within one business day, of the date of hire or the date of termination of their attendant and ensure 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;
- Notifying and submitting a report of an incident to the PCS agency within 24 hours of such incident, so the PCS agency can submit an incident report on behalf of the consumer; the consumer or their legal representative is responsible for completing the incident report;
- Ensuring 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.
- Obtaining a signed agreement from the attendant, in which the attendant agrees that they will not provide PCS while under the influence of drugs or alcohol and acknowledges that if they are under the influence of drugs or alcohol while providing PCS they will be immediately terminated; a copy of the signed agreement must be provided to the PCS;

- Ensuring if the attendant is the consumer's legal representative or legally responsible individual 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 or legally responsible individual 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;
- Signing an agreement accepting responsibility for all aspects of care and training including mandatory training in cardiopulmonary resuscitation (CPR), 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;
- 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.;
- Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;
- Allowing the PCS provider to maintain at least a minimum of quarterly in-person contact;
- 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;
- 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
- Complying with all Medicaid rules, regulations, and PCS requirements.

- 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 they are also a legal representative, but may assist the consumer in communicating, as appropriate. A personal representative may not be a personal care attendant, unless they are 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.

Agency Provider Requirements:

- Eligible PCS Agencies: PCS agencies electing to participate in providing PCS must obtain agency certification.
- PCS agency approval: A PCS agency providing either the consumer directed, the consumer delegated, or both models, must comply with the requirements of this section. A PCS agency may only serve members in the counties that are approved by HCA. An agency listing, by county, is maintained by HCA/MAD or its designee. All Medicaid approved PCS agencies are required to select a county in which to establish and maintain an official office for conducting business with a published phone number and hours of operation; home offices are acceptable as long as they meet these requirements. The PCS agency must provide services in all areas of the county in which the main office is located. Upon HCA approval, the PCS agency may elect to serve any county within 100 miles of the main office. Proof of service areas being within 100 miles when driving may be required. The PCS agency must provide PCS services to all areas of all selected counties. The PCS agency may establish multiple offices within the state as long as each office meets the outlined requirements and is approved by HCA/MAD/LTSSB.. Proof of an established business license for the city/county of the office(s) may be required..
- 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 completed Medicaid PPA (also known as the MAD 335);
  - 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; 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;

- Proof of liability and workers' compensation insurance (if certified, proof of liability and workers' compensation insurance must be submitted annually to HCA and the MCO); and
- A copy of written policies and procedures that address:
  - Medicaid's PCS provider rules and regulations;
  - Personnel policies; and
  - Office details that include but are not limited to:
    - 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;
    - Meeting all ADA requirements; and
    - If PCS agencies have branch offices, the branch office must have a qualified onsite administrator to handle day-to-day operations and receive direction and supervision from the main/central office;
- Quality improvement (QI) to ensure adequate and effective operation, including documentation of quarterly activity that addresses, but is not limited to:
  - Service delivery;
  - Operational activities;
  - Critical incident and significant events management practices;
  - QI action plan;
  - Documentation of QI activities;
- Agency operations to furnish services as consumer-directed or consumer-delegated, or both;
- A copy of a current and valid home health license, issued by the DOH, Division of Health Improvement, licensing, and certification (pursuant to 7.28.2 NMAC) may be submitted in lieu of the requirements; 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; and
- 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:

- Communication skills;
- Patient/Member rights, including respect for cultural diversity;
- Recording of information for patient/client records;
- Nutrition and meal preparation;
- Housekeeping skills;
- Care of the ill and disabled, including the special needs populations;
- Emergency response (including CPR and first aid);
- Universal precautions and basic infection control; home safety including oxygen and fire safety;
- Incident management and reporting; and
- Confidentiality.

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 attend a mandatory Medicaid or its designee's provider training session prior to the delivery of PCS.

An agency will not be approved as a personal care agency if:

- 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; and
- 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:
    - 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, halfsiblings, 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); and

- 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.

- 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:
  - Furnishing services to Medicaid consumers that comply with all specified Medicaid participation requirements outlined in 8.302.1 NMAC, General Provider Policies and 8.308.2.9 NMAC, Provider Network Policies;
  - 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 they cannot authorize employment for their 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 they are not eligible for PCS services;
  - Using the HCA approved EVV system;
  - Maintaining appropriate recordkeeping of services provided and fiscal accountability as required by the PPA;
  - 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;
  - The PCS agency will, unless exempted by MAD or its designee, use an electronic system attendants will 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;

- 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;
- Providing either the consumer-directed or the consumer-delegated models, or both models;
- Furnishing to their consumers, upon request, information regarding each model; if the consumer chooses a model 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;
- Ensuring each consumer receiving PCS services has a current IPoC on file;
- Performing the necessary nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29172 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;
- Producing reports or documentation as required by Medicaid or its designee;

- Verifying consumers will not be receiving services through the following programs while they are receiving PCS: Medicaid HCBS through the DD or MF waivers; Medicaid certified NF, ICF/IID, PACE, or APS attendant care program; recipients of community transition goods or services may receive Planning Center Online (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;
- Processing all claims for PCS in accordance with the billing specifications from the MCO; payment shall not be issued without appropriate documentation;
- 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 their own care or is noncompliant with Medicaid rules and regulations; and
- 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:
  - 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;
  - Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer;
  - 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; and

o Submit 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:

- Death of the consumer:
  - Unexpected death is defined as any death of an individual caused by an accident, or an unknown or unanticipated cause; and/or

- 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;

▪ Other reportable incidents:

- Environmental hazard is defined as an unsafe condition that creates an immediate threat to life or health of a consumer;
- 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;
- 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 PCP; and/or
- Any reports made to APS.

o Informing the consumer and their attendant of the responsibilities of the agency;

o Developing an IPoC based on the assessment, services authorization, task list, and consideration of natural supports provided by the MCO;

o Providing an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;

o 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

o Maintaining documentation in the consumer's file regarding legal and personal representatives, as applicable.

- For agencies providing PCS under the consumer directed model, the responsibilities include:

▪ 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;

▪ 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;

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

- Obtaining from the consumer or their legal representative a signed agreement in which the attendant agrees that they will not provide PCS while under the influence of drugs or alcohol and acknowledges that if they are under the influence of drugs or alcohol while providing PCS they will be immediately terminated; the agency must maintain a copy of the signed agreement in the attendant's personnel file, for the consumer;
- Obtaining a signed agreement from each consumer accepting responsibility for all aspects of care and training, including mandatory training in CPR, 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;
- Encouraging the care giver to complete mental health first aid training and providing information on where the training can be obtained;
- 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 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 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;
- Establishing and explaining to the consumer necessary payroll documentation for reimbursement of PCS;
- 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;
- Arranging for unemployment coverage and workers' compensation insurance;

- 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;
- 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 their own care; and
- Maintaining a consumer file, and an attendant personnel file for the consumer, for a minimum of six years.

- For agencies providing PCS under the consumer delegated model, the responsibilities include, but are not limited to the following:
  - Employing, terminating, and scheduling qualified attendants; and/or
  - 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:
    - An overview of PCS;
    - Living with a disability or chronic illness in the community;
    - CPR, first aid training;
    - A written competency test with a minimum passing score of at least 80%; 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;
    - Documentation of all training must include at least: name of trainee, title of the training, source, number of hours, and date of training;
    - 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%; 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;
  - 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;

- Informing the attendant of the risks of Hepatitis B infection per current DOH or the Centers 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;
- Obtaining a copy of the attendant's current and valid State driver's license or other current and valid State photo identification 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;
- Complying with Federal and state labor laws;
- Preparing all documentation necessary for payroll;
- Complying with Medicaid participation requirements outlined in 8.302.1 NMAC, General Provider Policies;
- 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;
- Obtaining from the attendant a signed agreement, in which the attendant agrees that they will not provide PCS while under the influence of drugs or alcohol and acknowledges that if they are under the influence of drugs or alcohol while providing PCS, they will be immediately terminated;
- Ensuring, if the consumer has elected the consumer's legal representative as their 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;
- Establishing and explaining to all their consumers and all attendants the necessary documentation needed for reimbursement of PCS;

- Performing payroll activities for the attendants;
- Providing workers' compensation insurance for attendants; and/or
- 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:
  - Date of visit;
  - Time of visit to include length of visit;
  - Name and title of person conducting supervisory visit;
  - Individuals present during visit;
  - Review of IPoC;
  - Identification of health and safety issues and quality of care provided by attendant, and
  - Signature of consumer or consumer's legal representative;
  - If an in-person supervisory visit will negatively impact a Member's health or safety, a Member can request supervisory visits be done via video conference. These requests must be made to and approved by the Member's MCO. The MCO must verify that:
    - The Member's healthcare provider/doctor provided written request for the waiver of in-person visits,
    - The supervisory visit can be made via a video visit on their preferred platform,
    - The PCS provider has a process/policy in place to assure supervisory visit requirements can be fulfilled via a video visit.
    - The request is for no longer than six months. If the in-person visit must be waived for a longer period, the request must be renewed.
- Maintaining an accessible and responsive 24-hour communication system for consumers to use in emergency situations to contact the agency;
- Following current recommendations of DOH and CDC, as appropriate, for preventing the transmission of TB; and
- 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 277A1 et seq.

- 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:

- Being hired by the consumer (consumer-directed model) or the PCS agency (consumer-delegated model);
- Providing the consumer (consumer-directed), or the PCS agency (consumer-delegated), with proof and copies of their current valid state driver's license or current valid state photo identification, and if the attendant will be transporting the consumer, current valid driver's license and current motor vehicle insurance policy;
- Being 18 years of age or older;
- Ensuring, 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 PCS 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 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 they have signed their time sheet/log/check list verifying the services provided to the consumer;
- 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 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;

- Ensuring while employed as an attendant they 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 they are under the influence of drugs or alcohol while providing PCS they will be immediately terminated;
- May not be the consumer's representative, unless they are also the legal representative;
- If the attendant is a Member of the consumer's family, they 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, they 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);
- 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;
- Following current recommendations of DOH and CDC, as appropriate for preventing the transmission of TB;
- 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 must successfully pass a written personal care attendant competency test with at least 80% correct within the first three months of employment; and
- Use the EVV system to document when and where PCS were provided to the Member.

- 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.

- 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 HH or other State plan or LTC services. If a consumer is receiving hospice care, is a resident in an ALF, shelter home, or room and board facility, the MCO will perform a CNA and ensure the PCS does not duplicate the services that are already being provided. If ADL or IADL services are part of the hospice or ALF, 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.
- PCS are not furnished to an individual who is an inpatient or resident of a hospital, NF, ICF/IID, MH facility, correctional facility, other institutional settings, except for recipients of community transition goods or services.
- 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:
  - Such that there is no longer a shared living space with another consumer, they will be reassessed for services that were allocated between multiple consumers in a shared household; or

  - Such that they begin sharing a living space with another consumer(s), all consumers in the new shared living space will be reassessed to determine the allocation of services shared by all consumers residing in the household.

- 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.
  - 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.
  - 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. Description of PCS refers to 8.308.12.13 NMAC.
  - General qualifications for Legally Responsible Individuals (LRI) who provide services:

- LRIs (e.g., the parent/guardian biological, legal or adoptive) of a minor child (under age 18) or the guardian of a minor child, who must provide care to the child, or a spouse of a Member, may be hired and paid for the provision of ABCB covered services under extraordinary circumstances in order to assure the health and welfare of the Member, to avoid institutionalization and provided that the state is eligible to receive Federal financial participation;
- Extraordinary circumstances include the inability of the agency to find and retain other qualified, suitable caregivers when the parent/guardian would otherwise be absent from the home and, thus, the parent/guardian must stay at home to ensure the Member's health and safety. The Member may request that the LRI (parent/guardian or spouse) be allowed to be employed by the Member/EOR and provide services as approved in the Member's current ABCB care plan. The request must include documentation showing all attempts to employ other available resources in the Member's community, the challenges the Member and/or providers encountered, and why the Member chosen providers were unable to successfully provide the approved covered service as approved in the ABCB care plan;
- LRIs may not be paid for any services that they would ordinarily perform in the household for individuals of the same age who do not have a disability or chronic illness. This includes, but is not limited to, transportation of minors to and from school, activities and events; and
- Requests to employ an LRI must be submitted in writing to the MCO by the provider. The request must be approved or denied in writing by the appropriate MCO/UR staff Member. The approval of an LRI must be renewed annually, at the same time as the NF LOC.

- 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.

- 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.
- 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.
- Any relevant sections of the CNA and the personal care service allocation tool is sent to the PCS agency by the MCO to allow the PCS agency to develop the IPoC.
- 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:
  - There is a change in the consumer's condition (either improved or declined);
  - There is a change in the consumer's natural supports or living conditions; and/or
  - The consumer requests and interim assessment.

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

- The MCO will issue a prior authorization to the PCS agency. A PCS authorization cannot extend beyond the LOC period and must be provided to the PCS agency prior to the prior authorization effective date and may not be applied retroactively.
- 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.
- Continuation of benefits: A Member may continue PCS benefits while an MCO grievance and
- or State fair hearing decision is pending, pursuant to 8.352.2 NMAC, Recipient Hearings, if the Member requests continuation of benefits within 10 calendar days of the date of the Notice of Action.
- 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 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.

- 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 PCS agency, with the consumer's consent, may use the authorized allocation of hours in an individualized schedule. The individualized schedule of services allows the consumer and PCS agency flexibility while maintaining a focus on the consumer's health and safety. The IPoC will clearly document the consumer's consent to the schedule. The PCS agency and consumer will develop the schedule for the number of days-per-week and hours-per-day to complete the needed ADL and IADL assistance. The PCS agency shall establish the appropriate monitoring protocols to ensure this flexible schedule does not adversely affect the consumer's health and safety.

  Should the MCO determine, based on care coordination, IPoC reviews, or other quality oversight that the IPoC does not adequately meet the consumer's needs or has created a health and/or safety concern, the MCO will communicate a request to the PCS Agency that the IPoC will need to be

adjusted to ensure the consumer's care needs are met. The PCS agency will follow the standard IPoC process utilizing the PCS Allocation Tool and will resubmit the IPoC for re-review within seven calendar days from receipt of request by the MCO.

- The PCS agency must:
  - 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;
  - Ensure the consumer has participated in the development of the plan and the IPoC is reviewed and signed by the consumer or the consumer's legal representative; a consumers' signature on the IPoC indicates 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;
  - 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;
  - Submit the IPoC to the MCO for review if the IPoC varies from the PCS Allocation Tool; Provide the consumer with a copy of their approved IPoC;
  - Obtain an approved task list and/or CNA;
  - Obtain written verification the consumer, or the consumer's legal representative, understands 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
  - 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.

- Members who wish to receive fewer PCS hours than initially authorized would discuss with their PCS provider and Care Coordinator. The Member and Care Coordinator will work together to determine if reducing hours is reasonable. If so, the Member will sign a new Community Benefit Member Agreement (CBMA). In this agreement, they would specify the reduced number of hours they require and any additional comments about the reduction. Subsequently, both the agency and the Member can collaboratively revise the Member's Individual Plan of Care (IPoC) to reflect this reduced hour commitment. PCS are to be delivered only in the State of New Mexico. However, consumers who require PCS out of the state may request an 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 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:
    - The consumer’s name and SSN;
    - How time sheets/logs/check-off list will be transmitted and payroll checks issued to the attendant;
    - Date the consumer will be leaving the state, including the date of the medical procedure or other medical event, the anticipated date of return;
    - Where the consumer will be housed after the medical procedure;
  - A letter or documentation from the physician, surgeon, physician assistant, nurse practitioner, or clinical nurse specialist verifying the date of the medical procedure; and
  - 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 they are out-of-state.
    - Utilization Review (UR): All PCS require prior LOC approval by the MCO; therefore, retroactive services are not authorized. All PCS are subject to UR for medical necessity and program compliance. The MCO will perform UR for medical necessity. The MCO makes final authorization of PCS using:
    - The HCA approved LOC criteria; and

- The CNA.

- 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 their MCO. Transfers may only be initiated by the consumer, their legal representative, or by a PCS agency on behalf of a consumer or their 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:

- The consumer must inform their MCO of the desire to transfer to another PCS agency;
- The consumer must complete a MAD 062 or an approved transfer form to include: the consumer's signature; the date of the signature of the receiving PCS agency; and the justification for the transfer;
- The MCO will process the transfer request within 15 business days after receipt of the transfer request;
- 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;
- Originating agencies are responsible for continued provision of services until the transfer is complete;
- 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 DOS 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; and

The following outlines the MCO review process for PCS agency transfers:

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

- The Care Coordinator will ask the consumer or their 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 the caregiver, the Care Coordinator should ask why the consumer is requesting a transfer;
- 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;
- If, during the review process, the MCO determines 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 (CAP). 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 need to be addressed by the MCO and corrected by the agencies;
- If, during the course of the review process, the Care Coordinator finds that the consumer has requested three 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 consider whether to approve or deny the transfer;
- The consumer and/or legal guardian will not be allowed to hire an individual to be their 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 the Medicaid PCS policies;
- When reviewing a transfer request, the MCO should take into consideration 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 the consumer's options have been explained and the consumer fully understands their options, and the service model selected is available to the consumer;
- The Care Coordinator should ensure the location of the agency or provider is convenient to the consumer;
- 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 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; and

A transfer requested by a consumer may be denied by the MCO for the following reasons:

- The consumer is requesting more hours/services;
- The consumer's attendant or family Member is requesting the transfer;
- The consumer has requested three or more transfers within a six-month period;
- The consumer wants their legal guardian or attorney-in-fact to be their attendant;
- The consumer wants an individual to be their attendant who has not successfully passed a nationwide criminal history screening;
- The consumer wants an attendant who has been terminated from another agency for fraudulent activities or other misconduct;
- The attendant does not want to complete the mandated trainings under the consumer-delegated model;
- The consumer does not wish to comply with the Medicaid or PCS regulations and procedures; and
- There is reason to believe that solicitation has occurred as defined in this policy in the, Solicitation/Advertising Section in this Manual.

- 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.
- Consumer Discharge: A consumer may be discharged from a PCS agency.
- 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 they must exhaust the grievance and appeal process with the MCO before a fair hearing can be filed with HCA pursuant to 8.352.2 NMAC, Recipient Hearings. The notice must include the justifiable reason for the agency's decision to discharge.

- A justifiable reason for discharge may include:
  - Staffing problems (i.e., excessive request for change in attendants, such as three or more during within 30 calendar days);
  - A consumer demonstrates a pattern of verbal or physical abuse toward attendants or agency personnel, including the use of vulgar or explicit (i.e., sexual) 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;
  - 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;
  - Illegal use of narcotics or alcohol abuse;
  - Fraudulent submission of timesheets; or
  - 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.
- 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.
- 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 HCA as outlined in 8.352.2 NMAC, Recipient Hearings.
- 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:

- 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;
- 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;
- A consumer or family Member who demonstrates a pattern of uncooperative behavior including, noncompliance with agency, Medicaid program requirements or regulations or procedures;
- Illegal use of narcotics, or alcohol abuse;
- Fraudulent submission of timesheets;
- Unsafe or unhealthy living conditions or environment; and/or
- PCS agencies and the MCO are responsible for documenting and reporting any incidents involving a consumer to Medicaid or its designee.

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.

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:

- Consumer notification letter;
- List of all the Medicaid approved personal care agencies serving the county in which the consumer resides; and
- List of all consumers currently being served by the agency and the MCO in which they are enrolled.

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.

- Prohibited solicitation includes, but is not limited to, the following:
    - Contacting a consumer who is receiving services through another PCS or any another Medicaid program;
    - Contacting a potential consumer to discuss the benefits of its agency, including door-to-door, telephone, mail and email solicitation;
    - Offering a consumer/attendant a finder's 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;
    - 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;
    - Making false promises;
    - Misinterpretation or misrepresentation of Medicaid rules, regulations or eligibility;
    - Misrepresenting itself as having affiliation with another entity; and/or
    - Distributing PCS-related marketing materials.

- 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.
- 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.
- Advertising for the purpose of hiring caregivers/employees is not prohibited and does not require prior approval from Medicaid.

Sanctions and Remedies

Any agency or contractor that is not compliant with the applicable Medicaid regulations is subject to sanctions and remedies as provided in 8.351.2 NMAC.

8.16. Private Duty Nursing (PDN) for Adults

PDN 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 PDN require the skills of a licensed RN or an LPN under a written physician's order in accordance with the New Mexico Nurse Practice Act, Code of Federal Regulation for Skilled Nursing. PDN services are planned in collaboration with the physician, the Member, and the MCO Care Coordinator. All services provided under PDN are pursuant to a physician's order and in conjunction with the MCO. The private duty nurse will develop and implement a PCCP/Treatment (CMS form 485) that is separate from the CCP developed by the MCO. Members do not have to be homebound in order to receive this service. PDN and Medicare/Medicaid skilled nursing may not be provided at the same time. PDN services offered through the ABCB program will vary in scope and duration from Medicare and Medicaid skilled nursing. PDN services will be offered to members who are 21 years of age and older receiving the CB 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 PDN provider and shared with the MCO Care Coordinator. Children (individuals under the age of 21) receive this service through the EPSDT.

PDN services are provided with the understanding that the MCO is the payer of last resort. PDN 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.

Scope of Services/Requirements:

Specific services may include the following:

- Obtaining pertinent medical history;
- Observing and assessing the Member's condition;
- Administration of medications including: oral, parenteral, gastrostomy, jejunostomy, inhalation, rectal and topical routes;
- Providing wound care, suture removal and dressing changes;
- Monitoring feeding tubes (i.e., gastrostomy, nasogastric, or jejunostomy including patency), including signs of possible infection;
- Monitoring bladder program and providing care, including ostomy and indwelling catheter insertion and removal;
- Monitoring aspiration precautions;
- Monitoring administration of oxygen, ventilator management, and Member's response;
- Monitoring infection control methods;
- Monitoring seizure protocols;
- Collecting specimens (blood, urine, stool, or sputum) and obtaining cultures as ordered by the Member's primary physician;
- Alerting the Member's physician to any change in health status;
- Monitoring nutritional status of the Member and reporting any changes to the physician and nutritionist if available;
- Maintaining Member intake and output flow sheets as ordered by the physician;

- Performing physical assessments including monitoring of vital signs and the Member's medical condition as warranted;
- 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;
- Providing staff supervision of appropriate activities, procedures and treatment;
- Developing the PCCP/treatment 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 PCCP/treatment (CMS form 485) on the basis of the Member assessment and evaluation;
- Analyzing and interpreting Member's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings;
- Developing interventions to assist the Member to achieve and promote health to meet the Member's needs;
- Developing individualized service goals, identifying short and long-term goals that are measurable and objective; and/or
- Documenting dates and types of treatments performed, as well as Member's response to treatment and progress toward all goals.

Requirements include the following:

- 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;
- PDN services listed in the PCCP are to be within the scope of the New Mexico Nurse Practice Act, are provided subsequent to obtaining a physician's order and under the supervision of a RN. Physician's orders will contain the following:
    - The task to be performed;
    - How frequently the task is to be performed;
    - The duration that the order is applicable; and
    - Any individualized instructions. Additionally, a physician's order will be obtained for the revision of any PDN service and annually with the PCCP renewal, if PDN are to continue.

- The PDN supervisor will provide clinical supervision in the Member's home at a minimum of once each quarter. Supervision of PDN services must be documented in the Member's clinical record;
- All services must be under the order of the Member's PCP. The order will be obtained by an RN working for the agency that provides PDN services, and will be shared with the MCO Care Coordinator;
- The PCCP/Treatment (Form CMS-485) will be provided to the MCO Care Coordinator. 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 PDN in accordance with the Care Plan. The provider agency will provide the MCO Care Coordinator with a copy of revised orders;
- 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 PCCP/Treatment;
- Reports must be current and available upon request of HCA/MAD;
- Reviewing and revising the PDN PCCP/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 CCP;
- 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;
- Reviewing physician's request for treatment. If appropriate, recommend revisions to the Care Plan to the MCO Care Coordinator by requesting a conference; and
- Providing Member and/or caregiver education regarding services. Document the date and time this occurred in the Member's clinical file.

Provider Requirements/Qualifications:

- PDN services must be provided by an active, Medicaid approved provider type 363, PDN provider;
- PDN providers must maintain (no gap in license) a full permanent license through the New Mexico Board of Nursing;

- PDN services may also be furnished through a licensed HH Agency, licensed RHC or certified FQHC who meet all requirements/qualifications in this section of the policy and are approved by the HCA/MAD/LTSSB as a provider type 363, PDN provider;
- PDN providers must comply with provision of the Nurse Practice Act and all city, state and federal rules/regulations;
- In order to be approved and certified by the HCA/MAD LTSSB, PDN providers must be operating with a full permanent license. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted. Provisional licenses will not be accepted; and
- PDN providers must comply with all applicable State and Federal rules and regulations under the Nurse Practice Act and program standards determined by HCA/MAD including but not limited to CBCs, OSHA training requirements, incident management system reporting, labor laws, etc.

Staffing Requirements:

- An RN or LPN is considered a qualified private duty nurse when the following criteria are met:
  - Must have current (no gaps in license) licensure as required by the state of New Mexico; provisional licenses are not acceptable;
  - Nursing experience preferably with disabled and elderly individuals. This includes settings such as HH, hospital, NF facility, or other types of clinics and institutions;
  - Nursing services must be furnished through a licensed HH Agency, licensed RHC or certified FQHC;
  - RNs who supervise must have at least one year of supervisory experience. Supervision of LPNs must be provided by an RN 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;
  - 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; and
  - 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.

Reimbursement

PDN providers are responsible for providing clinical documentation that identifies their 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 CCP that is coordinated with the Member/Member's 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 program. Billing is on an hourly basis and is accrued and rounded to the nearest quarter of an hour. Reimbursement for PDN for adults will be based on the negotiated rate with the MCO. Providers have the responsibility to review and ensure 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.

- Payment for PDN services is through the MCO and is considered payment in full.
- PDN services must abide by all Federal, state, HCA, policies and procedures regarding billable and nonbillable items.
- PDN providers must ensure all insurance records are maintained correctly.
- Billable hours are as follows:
    - Face-to-face activities that are described above in the scope of service for PDN;
    - Attendance and/or telephone conference call to participant in IDT meetings;
    - Development of the PCCP/Treatment, not to exceed four hours annually; and
    - Training on Member specific issues is reimbursable and included in the negotiated rate; general training requirements are an administrative cost and not billable.

Limits or Exclusions

- HCA/MAD does not consider the following to be professional PDN services and will not authorize payment for the following nonbillable activities:
    - Performing specific errands for the Member and/or family that are not program specific;
    - Friendly visiting;

- Financial brokerage services, handling of Member finances, or preparation of legal documents;
- Time spent on paperwork or travel that is administrative for the provider;
- Transportation of members;
- Pick up and/or delivery of commodities; and
- Other non-Medicaid reimbursable activities.

8.17. 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 CCP. A primary caregiver is the individual who has been identified in the PCCP 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 nursing respite services. Nursing respite services may be provided in the Member's home, in the nursing respite provider's home, and in the community. Nursing respite services may be provided by an RN, or an LPN. Nursing respite services are limited to a total maximum of 300 hours per PCCP year. Nursing respite provider agencies will use the state mandated EVV system as required by the 21st Century Cures Act.

Scope of Services/Requirements:

Specific services may include the following:

- Assistance with routine ADLs such as bathing, eating, meal preparation, dressing, and hygiene;
- Assistance with routine IADLs such as general housekeeping;
- Assistance with PCS or PDN services, based on the Member's needs;
- Assistance with the enhancement of self-help skills;
- Assistance with providing opportunities for leisure, play and other recreational activities~~.~~;

Requirements include the following:

- Nursing Respite services are available to any Member of any age;
- Nursing Respite services are determined by the MCO Care Coordinator and documented on the CCP;
- Scheduling of hours for use of nursing respite services is the responsibility of the nursing respite provider and the Care Coordinator; and

- Nursing respite services provided by a PDN provider requires a physician's order that includes the scope and duration of service(s). A new physician's order will be obtained annually with the CCP renewal or when there is a revision in the service. The order must be obtained by the agency providing PDN and shared with the MCO Care Coordinator. The provider agency may require advanced notice from the Member/family for provision of services and will notify members of their advanced notice requirement. The provider of nursing respite services must maintain a cumulative record of utilization of respite care, to include time used.

Provider Requirements/Qualifications:

The provider agency of nursing respite services must meet all requirements, certifications, and training standards set forth by the HCA/MAD to provide PDN services, as described in this section of the policy.

- Nursing respite services must be provided by an active, Medicaid approved provider type 363 Nursing Respite provider.
- Nursing respite providers must maintain (no gap in license) a full permanent license through the New Mexico Board of Nursing. Provisional licenses will not be accepted.
    - Nursing respite services may also be furnished through a licensed HH Agency, licensed RHC or certified FQHC who meet all requirements/qualifications in this section of the policy and are approved by the HCA/MAD/LTSSB as a provider type 363 nursing respite provider.
- Nursing respite providers must comply with provisions of the Nurse Practice Act and the state rules/regulations.
- In order to be approved and certified by the HCA/MAD/LTSSB, Nursing respite providers must be holding and operating with a full permanent license (no gaps in license). All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- Nursing respite providers must comply with all applicable State and Federal rules and regulations under the nurse practice Act and program standards determined by HCA/MAD including but not limited to CBCs, OSHA training requirements, incident management system reporting, labor laws, etc.;

- Nursing respite providers must have a functioning office located in New Mexico where staff and members can go to obtain information and/or assistance.
- The provider agency of nursing respite services must meet all requirements, certifications, and training standards set forth by the HCA/MAD to provide PDN services, as described in this section of the policy.

Staffing Requirements:

- An RN or LPN is considered a qualified respite nurse when the following criteria are met:
  - Must be holding and maintaining a current (no gaps in licensure) permanent license as required by the state of New Mexico;
  - Nursing experience preferably with disabled and elderly individuals. This includes settings such as HH, hospital, NF facility, or other types of clinics and institutions;
  - RNs who supervise must have at least one year of supervisory experience. Supervision of RNs and LPNs must be provided by a qualified RN on a quarterly basis 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;
  - 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; and

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.

Supervision of nursing respite 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.

Nursing respite providers must maintain a current roster that is updated quarterly of nurse respite providers to provide services as requested by the Member or family.

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 CCP.

Reimbursement

Reimbursement is on an hourly basis and is accrued to the nearest quarter of an hour. Training on Member specific issues is reimbursable and included in the negotiated rate, general training requirements are an administrative cost and not billable.

Reimbursement for nursing respite services will be based on the negotiated rate with the MCO. Providers of service have the responsibility to review and ensure the information on the prior authorization for their services is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.

Limits or Exclusions

The Member cannot schedule their own nursing respite with the nursing respite staff. The Member may receive a maximum of 300 total hours of nursing respite hours annually per CCP year provided there is a primary caregiver. Additional hours may be requested if an eligible Member's health and safety needs exceed the specified amount.

8.18. Respite Services

Respite services provide the Member's primary caregiver with a limited leave of absence to prevent burnout, to reduce stress and provide temporary relief to meet a family crisis, emergency or caregiver's illness as determined in the CCP. A primary caregiver is the individual who has been identified in the CCP and who assists the Member on an intermittent basis (i.e., daily or as needed). Respite services provide a temporary relief to the primary caregiver during times when they would normally provide unpaid care. If a caregiver needs a break during the time when they provide paid care, the agency must provide a substitute caregiver. Respite services may be provided in the Member's home, in the respite provider's home and/or in the community. Respite services are limited to a total maximum of 300 hours per CCP year. Respite services does not cover or provide skilled care. If a Member requires skilled care, that care must be provided by a PDN or a nursing respite provider approved as a provider type 363, nursing respite provider. Respite services are provided pursuant to the CCP, developed and authorized by the Member and the MCO Care Coordinator. Additional hours may be requested if an eligible Member's health and safety needs exceed the specified amount.

Scope of Services/Requirements:

Specific respite services may include the following:

- Household Activities – The following household activities are considered necessary to maintain a clean and safe environment and to support the Member 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 rooms in a house of six rooms. In this case, the respite 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:
    - Sweeping, mopping or vacuuming of carpets, hardwood floors, or linoleum;
    - Dusting of furniture;
    - Changing of linens;
    - Doing laundry (Member's clothing and linens only);
    - Cleaning bathrooms (tub and/or shower area, sink, and toilet); and/or
    - 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.
- 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.
- Personal Care – The CCP may include the following tasks to be performed by the respite provider:
    - Bathing – Giving a sponge bath/bed bath/tub bath/shower, including transfer in/out;
    - Dressing – Putting on, fastening, removing clothing; including prosthesis;
    - Grooming – Shampooing, combing or brushing hair, applying makeup, trimming beard or mustache, braiding hair, shaving under arms or legs as requested by the Member;
    - 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;

- 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;
- Perineal Care – Cleansing of the perineal area and changing of sanitary napkins;
- Toileting – Transferring on/off toilet, bedside commode and/or bedpan; cleaning perinea area, changing adult briefs/pads, readjusting clothing;
- 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 their physician, and are able to communicate their bowel care verbally or in writing. A physician must prescribe a bowel program for the Member. An RN 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 they are able to properly implement the bowel program according to the physician's order(s);
- 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 their physician and are able to communicate their bladder care verbally or in writing. A physician must prescribe a bladder program for the Member. An RN 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 they are able to properly implement the bladder program according to the physician's order(s);
- Mobility Assistance – Assistance in ambulation, transfer and toileting, defined as follows:
    - 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;
    - Transferring – Moving to/from one location/position to another with or without assistive device(s); and/or
    - Toileting – Transferring on or off toilet.
- Skin Care – Observation of skin condition for maintaining good skin integrity and prevention of skin infection, irritation, ulceration or pressure sores;

- Assisting with Self-administered Medication – Prompting and reminding only 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 services in this policy;
- 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;
- 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;
- Support Services – Support services provide additional assistance to members in order to promote independence and enhance their ability to remain in a clean and safe environment. The following support services will be identified in the assessment of the IADLs and are provided as determined in the Care Plan;
- Shopping and/or completing errands for the Member, with or without the Member;
- Accompanying or assisting with non-medical transportation~~.~~;
- Respite services are available to any Member of any age; and
- Respite services are determined by the MCO Care Coordinator and documented on the CCP.

Provider Requirements/Qualifications:

- Respite services must be provided by an active, Medicaid approved provider type 363 Respite provider.
- In order to be approved and certified by the HCA/MAD/LTSSB, respite providers must be able to demonstrate all requirements in this section are met. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted;
- 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 assesses 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.

- Respite agencies may be licensed by the DOH as an HH agency pursuant to 7.28.2.1 NMAC et seq. and must meet all requirements in this section of the policy to be approved as a Medicaid provider type 363 respite provider;
- Respite agencies must comply with DOH abuse registry screening laws regulations in accordance with the DOH Act, NMSA 1978, section 90706(E) and the Employee Abuse Registry Act, NMSA 1978, Sections 24-27-1 to 24-27-8;
- Respite agencies must provide incident management and review on an annual basis. Maintain documentation in the employee's personnel file as required by HCA/MAD;
  - Respite agencies must ensure written notification to the MCO Care Coordinator and provide the MCO with a copy of the incident report.
- Respite agencies must comply with all requirements set forth in the Medicaid PPA;
- 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 backup plan that ensures the Member's health and safety;
- 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; and
- Respite supervisors must provide specific instructions to assigned respite staff on each Member prior to providing services to the Member. It is the responsibility of the respite agency to ensure that respite caregivers are appropriately trained.

Reimbursement

Respite provider agencies must maintain appropriate record keeping of services provided to personnel and training documentation, and fiscal accountability as indicated in the Medicaid PPA. Billing is on an hourly basis 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 MCO. Providers of respite services have the responsibility to review and ensure 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.

ABCB respite provider agencies will use the state-mandated EVV system as required by the 21st Century Cures Act. Approved ABCB respite providers will complete the required EVV system training within 30 days of contracting with the MCOs.

Limits or Exclusions

Respite services cannot be included in the CCP in combination with Assisted Living. Respite services are limited to a total maximum of 300 hours per CCP year. Additional hours may be requested if an eligible Member's health and safety needs exceed the specified amount. Respite providers do not provide skilled services.

Scheduling of hours for use of respite services will be the responsibility of the Member or their representative. The provider agency may require advanced notice from the Member/family for provision of services and will notify members of their advanced notice requirement. The provider of respite services must maintain a cumulative record of utilization of respite care, to include time used. The Member may receive a maximum of 300 hours annually unless additional hours are approved by the MCO.

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.

8.19. Skilled Maintenance Therapies

Skilled maintenance therapies include Occupational Therapy (OT), Physical Therapy (PT) and speech and language therapy (SLT) for individuals 21 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.

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.

8.20. Occupational Therapy (OT) for Adults

OT is a skilled therapy service for individuals 21 years and older provided by a licensed occupational therapist. OT services promote/maintain fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. A signed OT referral for treatment must be obtained from the Member's PCP 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. The OT provider must develop a PCCP with the Member and share with the MCO Care Coordinator, which will be incorporated into the CCP. Children (under the age of 21) receive this service through EPSDT.

OT 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.

Scope of Services/Requirements:

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

- The occupational therapist must perform a comprehensive assessment evaluation for each Member to determine appropriate therapy, develop a PCCP and coordinate services with the MCO Care Coordinator. Services may include the following:
  - Obtaining pertinent medical history;
  - Assessing the Member for specific needs in gross/fine motor skills pertinent to OT;
  - Adapting the Member's environment in order to meet their needs;
  - Evaluating, administrating and interpreting tests;
  - 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;
  - Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to Member response;
  - Establishing individualized service goals and formulate a treatment plan/PCCP on the basis of the Member's evaluation;
    - 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;
    - Formulate a treatment plan/PCCP 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;
    - Review physician's request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings;
    - Implement and administer appropriate treatment;
  - Providing the Member or caregiver education and documenting in the Member's medical record;
  - 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;

- The staff: client rate is 1:1 for the period of time in which a specific Member is receiving therapy services; and/or
- Occupational Therapy services may be provided at:
  - A community-based center, i.e. therapy center;
  - The Member's home; and/or
  - Any other location in which the Member engages in day-to-day activities.

Provider Requirements/Qualifications:

- Occupational therapy services must be provided by an active, Medicaid approved provider type 363 Occupational therapy provider.
- Occupational therapists must comply with provisions of the Occupational Therapy Act and all other city, state and federal rules and regulations.
- Occupational therapists must maintain (no gaps in licensure) a full permanent Occupational therapist license from the New Mexico Regulation & Licensing Department. Provisional licenses will not be accepted.
- In order to be approved and certified by the HCA/MAD/LTSSB, Occupational Therapists must operate with a fully approved permanent license. All incomplete applications submitted to HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- OT experience preferably in in-home care and general acute care;
- Must have access to all required diagnostic and therapeutic materials to provide services;
- 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;
- 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;
- Certified Occupational Therapy Assistants (COTA) may perform OT procedures and related tasks pursuant to a PCCP 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;

- Provider agencies must adhere to the HCA/MAD requirements including but not limited to: OSHA training requirements, incident management reporting, CBC, labor laws, etc.;
- Provider agencies will establish and maintain financial reporting and accounting for each Member;
- All services must be under the order of the Member's PCP. The order will be obtained by the skilled therapist, and shared with the MCO Care Coordinator;
- Therapy reports must be current and available upon request of HCA/MAD; and
- OT providers must ensure all insurance records are maintained correctly in the Member's clinical file.
- The OT provider agency must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance.

Reimbursement

Providers are responsible for providing clinical documentation that identifies their role in all components of the provision of OT, 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's representative, other caregivers as applicable, and authorized by the MCO. All services provided, claimed, and billed must have documented justification supporting medical necessity. Reimbursement is on a per hour basis and rounded to the nearest quarter hour.

- Payment for OT services is based on the negotiated rate through the MCO and is considered payment in full. Providers of service have the responsibility to review and ensure the information on the prior authorization for their services is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.
- OT providers must abide by all Federal, State, HCA policies and procedures regarding billable and nonbillable items.
- Billable hours are as follows:
  - Face-to-face activities described in the Scope of Service;
  - Maximum of eight hours for an initial comprehensive individual assessment;
  - Maximum of eight hours to develop an initial comprehensive therapy plan;

- Attendance and/or telephone conference call to participate in IDT meetings;
- Annual maximum of six hours to complete progress reports and/or to revise annual plan;
- Annual maximum of eight hours to arrange assistive technology development;
- Training on Member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

Limits or Exclusions

- HCA does not consider the following to be professional OT services and will not authorize payment for the following nonbillable activities:
  - Performing specific errands for the Member and/or family that are not program specific;
  - Friendly visiting;
  - Financial brokerage services, handling of Member finances, or, preparation of legal documents;
  - Time spent on paperwork or travel that is administrative for the provider;
  - Transportation of members;
  - Pick up and/or delivery of commodities; and
  - Other non-Medicaid reimbursable activities.

8.21. Physical Therapy (PT) for Adults

PT is a skilled therapy service for members 21 years and older provided by licensed Physical therapist. PT services promote/maintain gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. A signed PT referral for treatment must be obtained from the Member's PCP 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. Children (under the age of 21) receive this service through EPSDT.

PT 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.

Scope of Services/Requirements:

- Providing professional assessment(s) of the individual for specific needs in gross/fine motor skills;

- Developing, implementing, modifying and monitoring PT treatments and interventions for the Member;
- Designing, modifying or monitoring use of related environmental modifications;
- Designing, modifying and monitoring use of related activities supportive to the Care Plan goals and objectives;
- Consulting or collaborating with other service providers or family members, as directed by the Member or Care Coordinator;
- Using of equipment and technologies or any other aspect of the Member's PT services;
- Training regarding PT activities;
- Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up.
- The physical therapist must perform a comprehensive assessment evaluation and develop a PCCP for each Member to determine appropriate therapy and coordinate services with the MCO Care Coordinator. Services may include the following:
    - Obtaining pertinent medical history;
    - Assessing of the Member on physical strengths and deficits including, but limited to:
        - Range of motion for all joints;
        - Muscle strength, gait pattern, sensation, balance, coordination, and perception;
        - Skin integrity and respiratory status;
    - Functional level of motor developmental level;
    - Adapting the Member's environment in order to meet their needs;
    - Evaluating, including the administration and interpreting tests and measurements within the scope of the therapist;
    - 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;
    - Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to Member response;
    - Establishing individualized service goals and formulate a treatment plan on the basis of the Member evaluation;

- 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. Formulate a treatment plan/PCCP 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;
- Review physician's request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings;
- Implement and administer appropriate treatment;
- Providing the Member or caregiver education and documenting in the Member's medical record; and
- 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.

- The staff to client ratio is 1:1 for the period-of-time in which a specific Member is receiving therapy services; and/or
  - Therapy services may be provided at:
    - A community-based center (i.e., therapy center);
    - The Member's home; and/or
    - Any other location in which the Member engages in day-to-day activities.

Provider Requirements/Qualifications:

- Physical therapy services must be provided by an active, Medicaid approved provider type 363 Physical therapist provider.
- Physical therapists must comply with all provisions and city, state and federal rules regarding physical therapy.
- Physical therapists must maintain (no gaps in licensure) a full permanent physical therapist license from the New Mexico Regulation & Licensing Department. Provisional licenses will not be accepted.

- In order to be approved and certified by the HCA/MAD/LTSSB, Physical Therapists must be holding and operating with a fully approved permanent license. All incomplete applications submitted to HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- The PT provider agency must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance.

- Staffing Requirements:
  - PT experience preferably in in-home care and general acute care;
  - Must have access to all required diagnostic and therapeutic materials to provide services;
  - 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;
  - 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; and
  - Certified Physical Therapy Assistants (PTA) may perform PT procedures and related tasks pursuant to a PCCP 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.
- Administrative Requirements:
  - Provider agencies must adhere to HCA/MAD requirements including but not limited to: OSHA training requirements, incident management reporting, CBC, labor laws, etc.;
  - All services must be under the order of Member's PCP. The order will be obtained by the skilled therapist, and shared with the MCO Care Coordinator; and
  - Therapy reports must be current and available upon request of HCA/MAD.

Reimbursement

Reimbursement for PT services will be based on the negotiated rate with the MCO. Providers of service have the responsibility to review and ensure that the information on the prior authorization for their

services is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.

PT services are provided with the understanding the MCO is the payer of last resort. PT 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.

Each provider of PT services is responsible to provide clinical documentation that identifies their role in all components of the provision of PT, 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.

- PT services must abide by all Federal, State, HCA policies and procedures regarding billable and nonbillable items; and
- PT providers must ensure all insurance records are maintained correctly.

Billable hours are as follows:

- Face-to-face activities described in the Scope of Service;
- Maximum of eight hours for an initial comprehensive individual assessment;
- Maximum of eight hours to develop an initial comprehensive therapy plan;
    - Attendance and/or telephone conference call to participate in IDT meetings;
    - Annual maximum of six hours to complete progress reports and/or to revise annual plan;
    - Annual maximum of eight hours to arrange assistive technology development;
        - Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour;
        - Training on Member specific issues is reimbursable, general training requirements are an administrative cost and not billable;

Limits or Exclusions

- HCA does not consider the following to be professional PT services and will not authorize payment for the following nonbillable activities:
  - Performing specific errands for the individual and/or family that are not program specific;
  - Friendly visiting;
  - Financial brokerage services, handling of Member finances, or, preparation of legal documents;
  - Time spent on paperwork or travel that is administrative for the provider;
  - Transportation of members;
  - Pick up and/or delivery of commodities; and
  - Other non-Medicaid reimbursable activities.

8.22. Speech Language Therapy (SLT) for Adults

SLT is a skilled therapy service for individuals 21 years and older provided by a licensed speech and language pathologist. SLT 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 PCP 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. Children (under age 21) receive this service through EPSDT.

SLT 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.

Scope of Services/Requirements:

Specific services may include the following:

- Identification of communicative or oropharyngeal disorders and delays in the development of communication skills;
- Prevention of communicative or oropharyngeal disorders and delays in the development of communication skills;
- Use of specifically designed equipment, tools, and exercises to enhance functional performance;
- Design, fabrication or modification of assistive technology or adaptive devices;
- Provision of assistive technology services;

- Evaluation, including administering and interpreting tests;
- Adapting the Member's environment in order to meet their needs;
- Implementation of the maintenance therapy plan;
- Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up;
- Consulting or collaborating with other service providers or family members; and
- Development of eating or swallowing plans and monitoring their effectiveness.
- 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:
    - Obtaining pertinent medical history;
    - Assessing for speech language disorders;
    - Assessing for swallowing disorders (dysphasia);
    - 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);
    - Assessing of oral motor function;
    - Assessing for the use of prosthetic/adaptive devices;
    - Assessing of resonance and nasal airflow;
    - Assessing of orofacial myofunctional patterns;
    - 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;
    - Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to Member response;
    - Establishing individualized service goals and formulate a treatment plan on the basis of the Member evaluation;
    - 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 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.;
- 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;
- Review physician's request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings;
- Implement and administer appropriate treatment;
- Providing the Member or caregiver education and documenting in the Member's medical record;
- 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;
- The staff to client rate is 1:1 for the period of time in which a specific Member is receiving therapy services; and
- Therapy services may be provided at:
  - A community-based center (i.e., therapy center);
  - The Member's home; and/or
  - Any other location in which the Member engages in day-to-day activities.

Provider Requirements/Qualifications:

SLT services must be provided by an active, Medicaid approved provider type 363 SLT provider.

SLT providers must maintain (no gaps in licensure) a full permanent license by the New Mexico Regulation & Licensing Department. Provisional licenses will not be accepted.

In order to be approved and certified by the HCA/MAD/LTSSB, SLT providers must be operating with a fully approved permanent license. All incomplete applications submitted to HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.

- Staffing Requirements:

- Graduation from an accredited masters or doctoral degree level, and holding the Certificate of Clinical Competence from the American Speech Language Hearing Association;
- Must have a current licensure by State of New Mexico;
- SLT experience preferably in in-home care and general acute care;
- Must have access to all required diagnostic and therapeutic materials to provide services;
- 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; and
- 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.

- Administrative Requirements:
  - Provider agencies must adhere to the HCA/MAD requirements including but not limited to: OSHA training requirements, incident management reporting, CBC, labor laws, etc.;
  - Provider agencies will establish and maintain financial reporting and accounting for each Member;
  - All services must be under the order of the Member's PCP. The order will be obtained by the skilled therapist, and shared with the MCO Care Coordinator; and
  - Therapy reports must be current and available upon request of HCA/MAD.
  - The SLT provider agency must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance.

Reimbursement

- SLT providers are responsible for providing clinical documentation that identifies their 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. Reimbursement is on a per hour basis and rounded to the nearest quarter hour.

- Payment for SLT services is based on the negotiated rate through the MCO and is considered payment in full. Providers of service have the responsibility to review and ensure the information on the prior authorization for their services is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.
- SLT services must abide by all Federal, State, HCA policies and procedures regarding billable and nonbillable items.
- Billable hours are as follows:
    - Face-to-face activities described in the Scope of Service;
    - Maximum of eight hours for an initial comprehensive individual assessment;
    - Maximum of eight hours to develop an initial comprehensive therapy plan;
    - Attendance and/or telephone conference call to participate in IDT meetings;
    - Annual maximum of six hours to complete progress reports and/or to revise annual plan;
    - Annual maximum of eight hours to arrange assistive technology development;
    - Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour; and
    - Training on Member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

Limits or Exclusions

- HCA/MAD does not consider the following to be professional SLT services and will not authorize payment for the following nonbillable activities:
    - Performing specific errands for the individual and/or family that are not program specific;
    - Friendly visiting;
    - Financial brokerage services, handling of Member finances, or, preparation of legal documents;
    - Time spent on paperwork or travel that is administrative for the provider;
    - Transportation of members;
    - Pick up and/or delivery of commodities; and
    - Other non-Medicaid reimbursable activities.
- SLT providers must ensure all insurance records are maintained correctly.

Services, Service Codes and Applicable Units of Service

SERVICE TYPE	CODE	UNIT INCREMENTS 1 UNIT =
Adult Day Health	S5100	15 minutes
Assisted Living	T2031	Day
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 Delivered Meals	S5170	1 meal = 1 unit
Home Health Aide	S9122	Hour
Nutritional Counseling	S9470	Hour
Personal Care-Consumer Directed	99509	Hour
Personal Care-Consumer Delegated	T1019	15 minutes
Personal Care-Directed training	S5110	15 minutes
Personal Care-Directed-Administrative Fee	G9006	1 unit + 1 month
Personal Care-Directed Advertisement Reimbursement Fee	G9012	1 Advertisement
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 minutes
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

Personal Care Services (PCS) Consumer Directed Model Code Definitions

Personal Care Consumer-Directed	99509	Hour	The rate for ongoing attendant services. The rate includes both the employee's and the employer's share of Social Security withholding and the cost for worker's compensation insurance. The maximum number of hours billable is determined by the authorization issued by the MCO which must be approved by the MCO Medicaid Utilization Review Department.
Personal Care Consumer-Directed Training	S5110	15 minutes	The rate for training provided to the consumer or their attendant at the request of the consumer. There is an annual maximum of eight (8) hours of training allowed per consumer.
Personal Care Consumer-Directed Advertisement Reimbursement Fee	G9012	1 unit = 1 advertisement	The maximum allowable rate for advertising. Consumers are reimbursed for up to two (2) advertisements per year if seeking a new Personal Care Attendant. If the billed amount exceeds the maximum allowable rate, the billed amount will be reduced to the maximum allowable rate. The advertising reimbursement is allowed only for actual and necessary advertising. Documentation is required in the case file.
Personal Care Consumer-Directed Administrative Fee	G9006	1 unit = 1 month	The rate for fiscal intermediary tasks such as processing payroll for the consumer's Personal Care Attendants, producing reports required by the Medical Assistance Division, processing claims for Consumer-Directed Personal Care services (including Income Tax and Social Security withholding) and submitting billings to the MCO.
Stipend PCS and Respite	G9006 U1	Month	The code for reimbursing an ABCB provider for the use of the caregiver's personal cell phone for clocking in an out of the EVV system. The caregiver will receive the full stipend amount set by the MCO.

Stipend PCS and Respite	G9006 U2	Month	The code for reimbursing an ABCB provider for the use of the caregiver's personal cell phone for clocking in and out of the EVV system. This code is used when the caregiver is providing PCS and/or Respite to two or more members from different MCOs.