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

8.308.12.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.12.1 NMAC - Rp, 8.308.12.1 NMAC, 3/1/2017; A, 7/1/2024]

8.308.12.2 SCOPE: This rule applies to the general public.
[8.308.12.2 NMAC - Rp, 8.308.12.2 NMAC, 3/1/2017]

8.308.12.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.12.3 NMAC - Rp, 8.308.12.3 NMAC, 3/1/2017; A, 7/1/2024]

8.308.12.4 DURATION: Permanent.
[8.308.12.4 NMAC - Rp, 8.308.12.4 NMAC, 3/1/2017]

8.308.12.5 EFFECTIVE DATE: March 1, 2017, unless a later date is cited at the end of a section.
[8.308.12.5 NMAC - Rp, 8.308.12.5 NMAC, 3/1/2017]

8.308.12.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division (MAD) programs.
[8.308.12.6 NMAC - Rp, 8.308.12.6 NMAC, 3/1/2017]

8.308.12.7 DEFINITIONS:

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

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

C. Authorized representative: The individual designated to represent and act on the member's behalf. The member or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the member.

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

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

F. Community benefits (CB): Services that allow a member to receive care in his or her home or in the community as an alternative to being placed in a long-term care facility. Services are intended to supplement natural supports and are not available 24-hours per day.

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

her care coordinator, support broker or both to develop a care plan which is submitted to the managed care organization (MCO) for review and approval.

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

I. Electronic Visit Verification (EVV): A telephone and computer based system that electronically verifies the occurrence of HSD selected services visits and documents the precise time the service begins and ends.

J. Eligible member: A medical assistance programs (MAP) enrolled MCO member who meets a specific level of care (LOC) and who selects to receive his or her MCO community benefits either through the ABCB or the self-directed community benefit (SDCB) approach. The eligible member must continue to meet a specific LOC and financial eligibility to continue accessing his or her MCO community benefits.

K. Employer of record (EOR): The employer of record is the individual responsible for directing the work of the member's SDCB employees, including recruiting, hiring, managing and terminating all employees. The EOR tracks expenditures for employee payroll, goods, and services. The EOR authorizes the payment of timesheets by the financial management agency (FMA). A member through the use of the EOR self-assessment instrument is either deemed able to be his or her own EOR or the member must assign the EOR duties to another eligible individual meeting specific EOR qualifications. A member who is a minor or a member who has a plenary or limited guardianship or conservatorship over financial matters in place is not able to be his or her own EOR. If the recipient is his or her own EOR and delegates any EOR responsibilities through a power of attorney (POA) or other legal instrument, the delegate must be the designated EOR. A POA or other legal instrument shall not be used to assign the responsibilities of an EOR, in part or in full, to another individual and shall not be used to circumvent the requirements of the EOR as designated in this rule.

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

M. Individual Plan of Care (IPoC): The plan for the provision of an ABCB member's personal care services. The plan is developed by the personal care services (PCS) agency and approved by the member's MCO.

N. Legally responsible individual (LRI): A legally responsible individual is any person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal, or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or a spouse.

O. Nursing Facility level of care (NF LOC): The member's functional level is such that (2) two or more activities of daily living (ADLs) cannot be accomplished without consistent, ongoing, daily provision, of some or all of the following levels of service: skilled, intermediate or assistance. A member must meet the NF LOC to be eligible for community benefit services.

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

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

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

[8.308.12.7 NMAC - Rp, 8.308.12.7 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.8 [RESERVED]

[8.308.12.8 NMAC - Rp, 8.308.12.8 NMAC, 3/1/2017]

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

[8.308.12.9 NMAC - Rp, 8.308.12.9 NMAC, 3/1/2017]

8.308.12.10 AGENCY BASED COMMUNITY BENEFIT (ABCB): The MCOs shall offer the ABCB

approach to its members who meet[s]the NF LOC and are determined through a CNA or reassessment to need MCO CB services. Although a member's assessment for the amount and types of services may vary, ABCB services are not provided 24 hours per day. A member has the option of choosing the ABCB or the SDCB approach. A member cannot participate in both community benefit approaches concurrently.
[8.308.12.10 NMAC - Rp, 8.308.12.10 NMAC, 3/1/2017]

8.308.12.11 ELIGIBLE ABCB PROVIDERS: All ABCB agencies must apply and be approved to be a MAD provider and must then contract with any or all approved MCOs. A complete listing of all CB provider qualifications and responsibilities are detailed in the MAD MCO policy manual. ABCB providers must meet all Federal requirements for home and community based providers.
[8.308.12.11 NMAC - Rp, 8.308.12.11 NMAC, 3/1/2017]

8.308.12.12 ELIGIBLE ABCB MEMBERS: A member must meet NF LOC and be determined through a CNA or reassessment to need MCO CB services.
[8.308.12.12 NMAC - Rp, 8.308.12.12 NMAC, 3/1/2017]

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

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

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

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

(3) Adult day health settings must be integrated and support full access of individuals receiving medicaid home and community-based services (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.

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

(1) Core services are a broad range of activities of daily living (ADL) including: personal support services (homemaker, chore, attendant services, meal preparation); companion services; medication oversight (to the extent permitted under state law); 24-hour on-site response capability:

(a) to meet scheduled or unpredictable member's needs; and

(b) to provide supervision, safety, and security.

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

(3) Assisted living settings must be integrated and support full access of individuals receiving Medicaid home and community-based services (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.

(4) Assisted living settings must meet CMS requirements for residential settings as outlined in the MAD MCO policy manual.

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

(1) Behavior support consultation:

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

(b) identifies support strategies for a member that ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior;

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

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

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

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

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

(1) Allowable expenses are those necessary to enable the member to establish a basic household that does not constitute room and board and may include:

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

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

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

(d) services necessary for the member's health and safety, such as, but not limited to, pest eradication and one-time cleaning prior to occupancy;

(e) moving expenses; and

(f) security deposit for an assisted living facility placement up to $500.

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

(3) Community transition services are limited to three thousand five hundred dollars ($3500) per member every five years. In order to be eligible for this service, the member must have a NF stay of at least 90-consecutive days prior to transition to the community.

E. Emergency response services provide an electronic device that enables a member to secure help in an emergency at his or her home, avoiding institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when the "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: testing and maintaining equipment; training the member, his or her caregivers and first responders on use of the equipment; 24-hour monitoring for alarms; checking systems monthly or more frequently (if warranted by electrical outages, severe weather, etc.); and reporting member emergencies and changes in the member's condition that may affect service delivery.

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

(1) The job coach provides:

(a) training, skill development;

(b) employer consultation that a member may require while learning to perform specific work tasks on the job;

(c) co-worker training;

(d) job site analysis;

(e) situational and vocational assessments and profiles;

(f) education of the member and co-workers on rights and responsibilities; and

(g) benefits counseling. The service must be tied to a specific goal in the member's care plan.

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

(a) job identification and development activities;

(b) employer negotiations;

(c) job restructuring;

(d) job sampling; and

(e) job placement.

(3) Employment supports are provided by staff at current or potential work sites. When

supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by the member receiving services as a result of his or her disabilities, and does not include payment for the supervisory activities rendered as a normal part of the business setting.

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

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

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

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

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

(6) Employment supports settings must be integrated and support full access of individuals 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.

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

(1) Adaptations include the installation of:

(a) ramps and grab-bars;

(b) widening of doorways and hallways;

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

(d) lifts and elevators;

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

(f) turnaround space adaptations;

(g) specialized accessibility/safety adaptations/additions;

(h) trapeze and mobility tracks for home ceilings;

(i) automatic door openers/doorbells;

(j) voice-activated, light-activated, motion-activated and electronic devices;

(k) fire safety adaptations; air filtering devices;

(l) heating and cooling adaptations;

(m) glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and

(n) alarm and alert systems, including signaling devices.

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

(3) Non-covered adaptations or improvements to the member's home include:

(a) adaptations for general utility which are not for direct medical or remedial benefit to the member; and

(b) adaptations that add to the total square footage of the member's resident except when necessary to complete an approved adaptation.

(4) The environmental modification provider must:

(a) ensure proper design criteria is addressed in planning and design of the adaptation;

(b) provide or secure the appropriate licensed contractor or approved vendor to provide construction and remodeling services;

(c) provide administrative and technical oversight of construction projects;

(d) provide consultation to members, family members, providers and contractors concerning environmental modification projects to the member's residence; and

(e) inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

(5) Environmental modification services to a member are limited to five-thousand dollars

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

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

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

(2) The home health aide services assist the member in a manner that promotes an improved quality of life and a safe environment for him or her. Home health aide services can be provided outside the member's home.

(3) Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home health aides perform an extension of therapy services including:

(a) bowel and bladder care;

(b) ostomy site care;

(c) personal care;

(d) ambulation and exercise;

(e) household services essential to health care at home;

(f) assisting with medications that are normally self-administered;

(g) reporting changes in patient conditions and needs; and

(h) completing appropriate records.

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

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

J. Personal care services (PCS) are provided to a member unable to perform a range of ADLs and instrumental activities of daily living (IADL). PCS shall not replace natural supports such as the member's family, friends, individuals in the community, clubs, and organizations that are able and consistently available to provide support and service to the member. Use of the Electronic Visit Verification (EVV) system is required for payment of PCS. The managed care organizations shall collaborate to offer a single EVV vendor for PCS and monitor compliance with the federal 21st Century Cures Act.

(1) PCS is a benefit for a member 21 years of age or older who meets the eligibility for CB services. A member under 21 years of age must access PCS through the EPSDT program.

(2) PCS delivery models: A member may select either the consumer-delegated or the consumer-directed delivery of his or her PCS. The PCS consumer-delegated or consumer-directed agency must be certified as such by MAD or it designee to perform such duties and to be reimbursed for the delivery model of those services. The MCO's care coordinator is responsible for explaining both models to each member, initially, and annually thereafter.

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

(b) The consumer-directed (PCS/CDirected) model allows the member to oversee his or her own PCS delivery, and requires that the member work with his or her PCS agency who then acts as a fiscal intermediary agency to process all financial paperwork to be submitted to the MCO.

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

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

(e) A member may have a relative, friend, or other spokesperson assisting him or her with communicating information or instructions to the member's attendant, providing information concerning

the member's natural services or supports needs during the member's assessment, or fulfilling additional roles as designated by the member or the member's authorized representative in writing. A spokesperson may not make decisions on behalf of a member, which is the member or member's authorized representative's sole responsibility, unless the member's authorized representative is also the member's spokesperson.

(3) Eligible PCS agencies: PCS agencies electing to provide PCS must obtain agency certification. A PCS agency provider, must comply with the requirements as listed in the MAD MCO policy manual PCS agencies must be an enrolled MAD provider.

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

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

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

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

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

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

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

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

(iii) cleaning perineal area,

(iv) changing adult briefs or pads;

(v) cleaning changing of wet or soiled clothing; and

(vi) assisting with adjustment of clothing before and after toileting.

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

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

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

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

(b) Services include:

(i) sweeping, mopping, or vacuuming;

(ii) dusting furniture;

(iii) changing linens;

(iv) washing laundry;

(v) cleaning bathrooms includes tubs, showers, sinks, and toilets;

(vi) cleaning the kitchen and dining area including washing dishes, putting them away; cleaning counter tops, and eating areas, etc.; household services do not include cleaning up after other household members or pets;

(vii) minor cleaning of an assistive device, wheelchair and durable medical

equipment (DME) is a covered service. A member must have an assistive device requiring regular cleaning that cannot be performed by the member and is not cleaned regularly by the supplier of the assistive device to be eligible to receive services under this category;

(viii) shopping or completing errands specific to the member with or without the member;

(ix) cueing a member to feed and hydrate his or her documented personal assistance animal or feed and hydrate such an animal when the member is unable;

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

(xi) assisting a member self-administering: assistance with self-administering physician ordered (prescription) medications is limited to prompting and reminding only. The use of over the counter medications does not qualify for this service. A member must meet the definition of "ability to self-administer" defined in this section, to be eligible to receive time for this task. A member who does not meet the definition of ability to self-administer is not eligible for this service. This assistance does not include administration of injections, which is a skilled/nursing task; splitting or crushing medications or filling medication boxes. Assistance includes: getting a glass of water or other liquid as requested by the member for the purpose of taking medications; at the direction of the member, handing the member his or her daily medication box or medication bottle; and at the direction of the member, helping a member with placement of oxygen tubes for members who can communicate to the caregiver the dosage or route of oxygen; and

(xii) transportation of the member: transportation shall only be for non-medically necessary events and may include assistance with transfers in and out of vehicles. Medically necessary transportation services may be a covered PCS service when the MCO has assessed and determined that other medically necessary transportation services are not available through other state plan services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) transferring to include moving to and from one location or position to another

with or without an assistive device such as in and out of a vehicle;

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

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

(10) Non-covered services: The following services are not covered as PCS:

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

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

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

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

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

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

(g) retroactive services;

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

(i) member assistance with finances and budgeting;

(j) member appointment scheduling;

(k) member range of motion exercises;

(l) wound care of open sores and debridement or dressing of open wounds;

(m) filling of medication boxes, cutting or grinding pills, administration of injections, assistance with over-the-counter medication or medication that the member cannot self-administer;

(n) skilled nail care for a member documented as medically at-risk;

(o) medically necessary transportation when available through the member's MCO general benefit services;

(p) bowel and bladder services that include insertion or extraction of a catheter or digital stimulation; and

(q) gastrostomy feeding and tube feeding.

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

(1) Services include:

(a) medication management;

(b) administration and teaching;

(c) aspiration precautions;

(d) feeding tube management;

(e) gastrostomy and jejunostomy;

(f) skin care;

(g) weight management;

(h) urinary catheter management;

(i) bowel and bladder care;

(j) wound care;

(k) health education;

(l) health screening;

(m) infection control;

(n) environmental management for safety;

(o) nutrition management;

(p) oxygen management;

(q) seizure management and precautions;

(r) anxiety reduction;

(s) staff supervision; and

(t) behavior and self-care assistance.

(2) All services are provided under a written physician's order and must be rendered by a

New Mexico board of nursing licensed RN or a licensed practical nurse (LPN) who provides services within his or her scope of practice.

L. Respite services are provided to a member unable to care for him or herself and are furnished on a short-term basis to allow the member's primary caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. Respite provides a temporary relief to the primary caregiver of a CB member during times when he/she would normally provide unpaid care.

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

(2) Respite care services include:

(a) medical and non-medical health care;

(b) personal care; bathing;

(c) showering; skin care;

(d) grooming;

(e) oral hygiene;

(f) bowel and bladder care;

(g) catheter and supra-pubic catheter care;

(h) preparing or assisting in preparation of meals and eating;

(i) administering enteral feedings;

(j) providing home management skills;

(k) changing linens;

(l) making beds;

(m) washing dishes;

(n) shopping; errands;

(o) calls for maintenance;

(p) assisting with enhancing self-help skills, such as promoting use of appropriate interpersonal communication skills and language, working independently without constant supervision or observation;

(q) providing body positioning, ambulation and transfer skills;

(r) arranging for transportation to medical or therapy services;

(s) assisting in arranging health care needs and follow-up as directed by primary care giver, physician, and care coordinator; and

(t) ensuring the health and safety of the member at all times.

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

(4) Respite services are limited to a maximum of 300 hours annually per care plan year. Additional hours may be requested if a member's health and safety needs exceed the specified limit.

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

(1) Physical therapy services promote gross and fine motor skills, facilitate independent functioning and prevent progressive disabilities. Specific services may include but are not limited to:

(a) professional assessment, evaluation and monitoring for therapeutic purposes;

(b) physical therapy treatments and interventions;

(c) training regarding PT activities;

(d) use of equipment and technologies or any other aspect of the member's physical therapy services;

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

(f) designing, modifying, and monitoring use of related activities supportive to the

care plan goals and objectives; and

(g) consulting or collaborating with other service providers or family enrollees, as directed by the member.

(2) Occupational therapy (OT) services promote fine motor skills, coordination, sensory integration, and facilitate the use of adaptive equipment or other assistive technology. Specific services may include but are not limited to:

(a) teaching of daily living skills;

(b) development of perceptual motor skills and sensory integrative functioning;

(c) design, fabrication, or modification of assistive technology or adaptive devices;

(d) provision of assistive technology services;

(e) design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;

(f) use of specifically designed crafts and exercise to enhance function; training regarding OT activities; and

(g) consulting or collaborating with other service providers or family enrollees, as directed by the member.

(3) Speech and language therapy (SLT) services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology; and prevent progressive disabilities. Specific services may include but are not limited to:

(a) identification of communicative or oropharyngeal disorders and delays in the development of communication skills;

(b) prevention of communicative or oropharyngeal disorders and delays in the development of communication skills;

(c) development of eating or swallowing plans and monitoring their effectiveness;

(d) use of specifically designed equipment, tools, and exercises to enhance function;

(e) design, fabrication, or modification of assistive technology or adaptive devices;

(f) provision of assistive technology services;

(g) adaptation of the member's environment to meet his or her needs;

(h) training regarding SLT activities; and

(i) consulting or collaborating with other service providers or family enrollees as directed by the member.

(4) A signed therapy referral for treatment must be obtained from the member's PCP. The referral will include frequency, estimated duration of therapy and treatment, and procedures to be provided.
[8.308.12.13 NMAC - Rp, 8.308.12.13 NMAC, 3/1/2017; A. 1/1/2019]

8.308.12.14 ABCB NON-COVERED SERVICES: MAD and the member's MCO do not cover certain procedures, services, or miscellaneous items. See specific MAD NMAC rules, sections of this rule, and the MAD MCO manual for additional information on benefit coverage and limitations.
[8.308.12.14 NMAC - Rp, 8.308.12.14 NMAC, 3/1/2017]

8.308.12.15 SELF-DIRECTED COMMUNITY BENEFIT (SDCB): The MCO shall offer the SDCB approach to a member who meets a NF LOC and is determined through a CNA or reassessment to need CB services. Self-direction affords a member the opportunity to have choice and control over how his or her CB services are provided and who provides the services. Although a member's assessment for the amount and types of services may vary, SDCB services are not provided 24 hours per day. Services are reimbursed according to the MAD fee schedule that has a range of allowable reimbursement rates to a provider of a specific service. The member's MCO approves the final reimbursement rate for each provider of a CB service. A member has the option of choosing the ABCB or the SDCB approach. A member cannot participate in both community benefit approaches concurrently.
[8.308.12.15 NMAC - Rp, 8.308.12.15 NMAC, 3/1/2017]

8.308.12.16 ELIGIBLE PROVIDERS:

A. The FMA, member or his or her EOR shall verify that a potential provider meets all applicable qualifications prior to rendering a service. If a provider or employee is unable to pass a nationwide criminal history screening pursuant to NMSA 1978, 29-12-2 et seq. or is listed in the abuse registry as defined in 27-7a-1 et seq., NMSA 1978 he or she may not be employed to render any service to the member. Following formal approval from the MCO, LRIs may serve as a SDCB provider under extraordinary circumstances in order to assure the health and

welfare of the member and to avoid his or her institutionalization. The MCO shall make decisions regarding LRIs serving as providers for members on a case by case basis. Following formal approval from the MCO, a spouse of a member may serve as a provider under extraordinary circumstances in order to assure the health and welfare of the member and to avoid institutionalization. The MCO shall provide such approval on a case by case basis. SDCB providers must meet all Federal and state requirements for home and community based providers.

B. An EOR shall have an employment agreement or vendor agreement with each of the member's providers. The employee or vendor agreement template shall be prescribed by MAD. Prior to a payment being made to a provider for SDCB services, the FMA shall ensure that: the provider meets all qualifications; and an employee agreement or vendor agreement is signed between the EOR and the provider. A member's employee agreement shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Employee agreements and vendor agreements shall be signed by the new EOR when there is a change in EORs. A copy of each employee agreement or vendor agreement shall be provided to the member and EOR. Refer to the MAD MCO policy manual for a complete listing of all SDCB provider qualifications and responsibilities.
[8.308.12.16 NMAC - Rp, 8.308.12.16 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.17 ELIGIBLE MEMBERS: A member must meet NF LOC, be determined through a CNA or reassessment to need MCO CB services, and be approved by the member's MCO for the SDCB approach.
[8.308.12.17 NMAC - Rp, 8.308.12.17 NMAC, 3/1/2017]

8.308.12.18 COVERED SERVICES IN SELF-DIRECTED COMMUNITY BENEFIT SDCB: MAD and the member's MCO cover certain procedures, services, and miscellaneous items. For those services that are the same in ABCB and SDCB, detailed descriptions are found in 8.308.12.13 NMAC. Other services may be available to a member in the SDCB approach and detailed descriptions are included in each subsection of this section.

A. Behavior support consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, his or her parents, family, and primary caregivers with coping skills which promote maintaining the member in a home environment. See Subsection C of Section 8.308.12.13 NMAC for a detailed description of this service.

B. Customized community supports include participation in community congregate day programs and centers that offer functional meaningful activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills. Customized community supports may include day support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings. These services are provided at least four or more hours per day one or more days per week as specified in the member's care plan. Customized community supports settings must be integrated and support full access of individuals 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.

C. Emergency response services provide an electronic device that enables a member to secure help in an emergency at his or her home, avoiding institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when the "help" button is activated. The response center is staffed by trained professionals. See Subsection E of Section 8.308.12.13 NMAC for a detailed description of this service.

D. Employment supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. Employment supports settings must be integrated and support full access of individuals 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. See Subsection F of Section 8.308.12.13 NMAC for a detailed description of this service.

E. Environmental modification services include: the purchase of, the installation of equipment for the physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance the member's level of independence. See Subsection G of Section 8.308.12.13 NMAC for a detailed description of this service.

F. Home health aide services provide total care or assist the member in all ADLs. See Subsection H of Section 8.308.12.13 NMAC for a detailed description of this service.

G. Self-directed personal care services (SD PCS) are provided on an episodic or continuing basis to assist the member with ADLs, performance of general household tasks, provide companionship to acquire, maintain, or improve social interaction skills in the community, and enable the member to accomplish tasks he or she would

normally do for him or herself if he or she did not have a disability.

(1) Self-directed PCS are provided in the member's home and in the community, depending on the member's needs. The member identifies the caregiver's training needs, and, if the member is unable to do the training himself or herself, the member arranges for the needed training.

(2) Self-directed PCS are not intended to replace supports available from a primary caregiver. Self-directed PCS are not duplicative of home health aide services.

(3) Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Self-directed PCS caregivers do not have this ability to perform such tasks.

(4) Use of the Electronic Visit Verification (EVV) system is required for payment of Self-directed PCS.

H. Non-medical transportation services are offered to enable a member to gain access to services, activities, and resources, as specified by his or her care plan. Payment for non-medical transportation is limited to the costs of transportation needed to access community benefit services, activities, and resources identified in the member's care plan. Payment for SDCB non-medical transportation services is made to the member's individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the member. Non-medical transportation services for minors is not a covered service. Non-medical transportation for members entering the SDCB on or after January 1, 2019 is limited to a maximum of $1,000 annually per care plan year.

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

J. Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for a member who is 21 years of age and older with intermittent or extended direct nursing care in his or her home. See Subsection K of Section 8.308.12.13 NMAC for a detailed description of this service.

K. Related goods are equipment, supplies or fees and memberships, not otherwise provided through the member's MCO general benefits.

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

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

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

(3) Services and goods that are recreational or diversional in nature are excluded. Recreational and diversional in nature is defined as inherently and characteristically related to activities done for enjoyment.

(4) Related goods for members entering the SDCB on or after January 1, 2019 are limited to a maximum of $2,000 annually per care plan year.

L. Respite services are provided to a member unable to care for him or herself and are furnished on a short-term basis to allow the member's primary caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. See Subsection L of Section 8.308.12.13 NMAC for a detailed description of this service.

M. Skilled maintenance therapy services for a member 21 years and older are provided when his or her MCO's general physical health benefit skilled therapy services are exhausted or not a covered MCO benefit. The community benefit skilled maintenance therapy services include physical therapy, occupational therapy or speech language therapy. Therapy services focus on improving functional independence, health maintenance, community integration, socialization, and exercise, and enhance the support and normalization of the member's family relationships. See Subsection M of 8.308.12.13 NMAC for a detailed description of this service.

N. Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his or her care plan when the services

enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services.

(1) Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or behavioral health condition by controlling and regulating the flow and balance of energy, form, and function to restore and maintain physical health and increased mental clarity to a member. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits to the member.

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

(3) Chiropractic care for a member is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, the adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health of the member.

(4) Cognitive rehabilitation therapy services for a member are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of ADL. The overall goal is to restore the member's function in a cognitive domain or set of domains, or to teach compensatory strategies to overcome specific cognitive problems.

(5) Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for a member with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the member use cognitive functioning, especially for sequencing and memory. A member with attention deficits and maladaptive behaviors is redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production of the member.

(6) Massage therapy for a member is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a member's ability to be more independent in the performance of ADL; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

(7) Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function for a member.

(8) A native American healer is an individual who is recognized as a healer within his or her respective native American community. A native American member may be from one of the 22 sovereign tribes, nations and pueblos in New Mexico or may be from other tribal backgrounds. A native American healer delivers a wide variety of culturally-appropriate therapies that support the member by addressing the member's physical, emotional and spiritual health. Treatments delivered by a native American healer may include prayer, dance,

ceremony and song, plant medicines and foods; participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel or other sacred objects. A native American healer provides opportunities for the member to remain connected with his or her tribal community. The communal and spiritual support provided by this type of healing can reduce pain and stress and improve quality of life. It is also important to note that some tribes, nations and pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious ties.

(9) Specialized therapies for members entering the SDCB on or after January 1, 2019 are limited to a maximum of $2,000 annually per care plan year.

O. Start-up goods are used when a member is transitioning from the ABCB model to the SDCB model. Start-up goods enable a member to begin to self-direct his/her services. Start-up goods include, but are not limited to, computers, printers and fax machines. Start-up goods are provided one-time during the member's first full or prorated care plan year and are limited to $2,000.

[8.308.12.18 NMAC - Rp, 8.308.12.18 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.19 SDCB NON-COVERED SERVICES AND SERVICE LIMITATIONS: MAD and the member's MCO do not cover certain procedures, services, or miscellaneous items. Services and goods that are not covered by the SDCB approach include, but are not limited to the following:

A. services covered by third-parties; MAD or the MCO is the payer of last resort;

B. any service or good, the provision of which would violate federal or state statutes, rules or guidance; this includes services that are considered primarily recreational or diversional in nature as defined in Paragraph (3) of Subsection K of Section 8.301.12.18 NMAC, including but not limited to, tickets for movies, theatrical and musical performances, sporting events, zoos, and museums;

C. formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the public education department (PED), division of vocational rehabilitation (DVR);

D. room and board, meaning shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing(s), home and property maintenance, utilities and utility deposits, and related administrative expenses; utilities include gas, electricity, propane, fire wood, wood pellets, water, sewer, and waste management;

E. experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC;

F. any goods or services that a household that does not include a person with a disability would be expected to pay for as a routine household expense;

G. personal goods or items not related to the SDCB member's condition or disability;

H. purchase of animals and the costs of maintaining animals, including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;

I. gas cards and gift cards; items that are purchased with SDCB program funds may not be returned for store credit, cash or gift cards;

J. purchase of insurance, such as car, health, life, burial, renters, home-owners, service warrantees or other such policies. This includes purchase of cell phone insurance;

K. purchase of a vehicle, and long-term lease or rental of a vehicle;

L. purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items;

M. firearms, ammunition or any other type of weapons;

N. gambling, games of chance (such as bingo or lottery), alcohol, tobacco, or similar items;

O. vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses; this also includes mileage or driver time reimbursement for vacation travel by automobile;

P. purchase of usual and customary furniture and home furnishings, unless adapted to the SDCB member's disability or use, or of specialized benefit to the SDCB member's condition; requests for adapted or specialized furniture or furnishings must include a doctor's order from the member's health care provider and, when appropriate, a denial of payment from any other source;

Q. regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, except upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the SDCB member's qualifying condition or disability;

R. regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, except upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the SDCB member's qualifying condition or disability; requests must include documentation that

the adapted vehicle is the SDCB member's primary means of transportation;

S. clothing and accessories, except adaptive clothing or accessories based on the SDCB member's disability or condition;

T. training expenses for paid employees;

U. conference or class fees may be covered for SDCB members or unpaid caregivers, but costs associated with such conferences or classes cannot be covered, including airfare, lodging or meals;

V. for member electronics such as cell phones, computers, printers and fax machines, or other electronic equipment, no more than one of each type of item may be purchased at one time, and member electronics may not be replaced more frequently than once every three years; laptops or any electronic tablets are considered computers;

W. home schooling materials or related supplemental materials and activities;

X. cell phone services that include more than one cell phone or cell phone line per SDCB member; cell phone service, including data, is limited to the cost of one hundred dollars per month; and

Y. moving expenses are limited to, the cost of moving truck rental, gas/mileage, labor, moving equipment, supplies, boxes, tape and moving blankets.

[8.308.12.19 NMAC - Rp, 8.308.12.19 NMAC, 3/1/2017; A, 1/1/2019]

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

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

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

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

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

(a) understand member and EOR roles and responsibilities;

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

(c) understand the array of SDCB services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) develop the care plan for SDCB based on the member's budget amount as determined by the CNA; and

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

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

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

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

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

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

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

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

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

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

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

(v) monitors hours billed for services provided and the total amounts billed

for all goods and services during the month;

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

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

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

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

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

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

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

(c) the services or goods must facilitate the member's ADL per his or her CNA;

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

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

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

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

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

(i) the service or good is not prohibited by federal regulations, applicable NMAC rules, supplements, the MAD MCO policy manual, service standards, and instructions;

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

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

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

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

F. SDCB back-up plan: The support broker shall assist the member and his or her EOR in developing a back-up plan for the member's SDCB services that identifies how the member and EOR will address situations when a scheduled provider is not available or fails to show up as scheduled. The member's support broker shall assess the adequacy of the member's back-up plan at least on an annual basis and when changes in the

type, amount, duration, scope of the SDCB or the schedule of needed services, or a change of providers (when such providers also serve as back-up to other members) or change in availability of paid or unpaid back-up providers to deliver needed care.

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

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

(a) understanding the role of the member and EOR with SDCB;

(b) understanding the role of the care coordinator, support broker, the MCO, and the FMA;

(c) selecting providers and vendors;

(d) critical incident reporting;

(e) member abuse and neglect prevention and reporting;

(f) being an employer, evaluating provider performance and managing providers;

(g) fraud and abuse prevention and reporting;

(h) performing administrative tasks, such as, reviewing and approving electronically captured visit information and timesheets and invoices; and

(i) scheduling providers and back-up planning.

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

H. Claims submission and payment: The EOR shall review and approve timesheets of the member's providers and invoices from the member's vendors to determine accuracy and appropriateness. No SDCB provider shall exceed 40 hours paid work in one work week per EOR. Timesheets must be submitted and processed on a two-week pay schedule according to the FMA's prescribed payroll payment schedule. The FMA shall be responsible for processing the member's timesheets and invoices for approved SDCB services and goods.
[8.308.12.20 NMAC - Rp, 8.308.12.20 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.21 TERMINATION FROM ABCB PCS/CDIRECTED OR SDCB: The MCO may involuntarily terminate a member from the PCS/CDirected or the SDCB approach under any of the following circumstances.

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

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

(1) the member refuses to include and maintain services in his or her PCS/CDirected or SDCB care plan that would address health and safety issues identified in the member's CNA or challenges the assessment after repeated and focused technical assistance and support from program staff, the care coordinator, PCS agency or the FMA;

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

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

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

(5) the member or authorized representative intentionally misuses the member's PCS/CDirected or SDCB services or goods.

C. The MCO shall submit to MAD any requests to terminate a member from the PCS/CDirected or the SDCB approach with sufficient documentation regarding the rationale for termination. Upon MAD approval, the MCO shall notify the member regarding termination in accordance with NMAC rules and MCO policies. The

member shall have the right to appeal the determination by requesting a MCO appeal and, if the termination is still upheld by the MCO, a HSD administrative hearing. Within 120 days of the final decision, the MCO shall facilitate a seamless transition from the PCS/CDirected to PCS/CDelegated or SDCB to ABCB to ensure there are no interruptions or gaps in services. Involuntary termination of a member from SDCB shall not affect a member's eligibility for ABCB covered services or continued MCO membership. However, a member that has been involuntarily terminated from SBCB must access PCS from the PCS/CDelegated model for at least one year. Involuntary termination of a member from PCS/CDirected shall not affect a member's eligibility for other CB services or PCS/CDelegated services.

D. A member who has voluntarily switched to PCS/CDelegated or ABCB or who has been involuntarily terminated from PCS/CDirected or from SDCB may request to be reinstated in the PCS/CDirected or the SDCB approach to his or her MCO. Such requests may not be made more than once in a calendar year. The member's PCS/CDirected or SDCB reinstatement when he or she was involuntarily terminated is at the discretion of his or her MCO. The care coordinator shall work with the member's PCS agency or FMA to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to such reinstatement. A member shall be required to participate in SDCB training programs prior to his or her SDCB reinstatement. A member shall be required to participate in PCS/CDirected training programs and the MCO may request the member's PCP provide a signed statement that the PCS/CDirected approach is appropriate for the member prior to his or her PCS/CDirected reinstatement.

[8.308.12.21 NMAC - Rp, 8.308.12.21 NMAC, 3/1/2017; A, 1/1/2019]

8.308.12.22 Electronic Visit Verification (EVV) System:

A. The MCO, together with the other MCOs, shall contract with a vendor to implement an EVV system in accordance with the federal Twenty First Century Cures Act.

B. The MCO shall maintain an EVV system capable of leveraging up-to-date technology as it emerges to improve functionality in all areas of the state, including rural areas.

[8.308.12.22 NMAC - N, 1/1/2019]

HISTORY OF 8.308.12 NMAC: [RESERVED]