Personal Care Service (PCS) Agency Requirements

Provider Training

Personal Care Services (PCS) Annual Audits

As part of the annual Agency Based Community Benefit (ABCB) audits, Managed Care Organizations (MCOs) audit PCS agencies to determine compliance with the requirements as defined in the Managed Care Policy Manual.

All elements of the audit are included under Section 8.14 of the Managed Care Policy Manual and Section 8.320.2.18.C NMAC.

The MCOs will also conduct an annual audit of the contracted Self-Directed Community Benefit (SDCB) Fiscal Management Agency.

MCO Introductions

Services Audited: Agency Based Community Benefits (ABCB)

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

ABCB Annual Audits

ABCB Annual Audits

- As part of LOD #25, MCOs will be required to monitor all Community Benefits providers annually to ensure compliance with all state and federal requirements.
  - MCOs will rotate auditing their contracted network each year. If an Agency is only contracted with one MCO, that MCO will be conducting the audit each year.
  - MCOs will be assigned a list of provider agencies in which to audit. MCOs will outreach to their assigned providers to request and obtain required documents.
  - When providing documents, please ensure to provide them **only** to the auditing MCO.
  - Depending on the services your agency provides, your agency may be required to complete two annual attestations.

    1.) ABCB Provider Attestation Form – All ABCB providers acknowledging roles and responsibilities as an ABCB provider (required annually)

    2.) Home and Community Based Services (HCBS) Attestation Form - Any residential or non-residential provider who offers agency-based community benefit services in a setting where individuals live and/or receive HCBS must comply with the provider setting requirements and complete an annual attestation. (Adult Day Health, Assisted Living, Employment Supports) (required annually)

ABCB Annual Audits

- The MCOs participate in an All MCO workgroup to discuss audit progress and results *(as necessary).* MCOs will be assigned specific providers to ensure that all ABCB providers are audited annually.
- Providers will only be audited once per calendar year, even if the provider is contracted with more than one MCO.
- Providers will receive a formal documentation request along with the All MCO audit tool with the details and a timeline to return the requested documents.
  - Providers are to submit the requested documentation within **thirty (30) calendar days** from the date of the letter.
  - Providers can request a Technical Assistance (TA) call if they have any questions regarding the audit.
- Upon completion of the audit, providers will receive a **Final Results letter** which will score providers as "compliant" or "non-compliant".
- Providers who are non-responsive or fail to comply with the audit will receive a **non-compliance letter.**
- Providers that do not comply with ABCB audit requirements may be sanctioned up to, and including, termination of their provider agreement by MCO.

Initial Documentation Request

Your agency will receive a letter via mail and email to your administrative and email address on file with MCO.

- The ABCB All MCO Audit Tool will be included.
- Each ABCB provider type will have its own tab on the audit tool, identifying the required audit elements.
- If you are an agency providing multiple services, (Respite, Personal Care Services etc.) you will be required to complete an audit for each service.

Timeline: You will have **30 calendar days** from the date of the letter to submit the required audit documentation.

MCO LETTERHEAD HERE

Date: *Date Letter Issued*

To: *Provider Name*
Mailing Address
Email Address

From: *MCO NAME HERE*

RE: Action Required: Documentation Request

[MCO] is conducting a desk audit of your agency. The purpose of this audit is to determine your agency's compliance with the requirements set forth for all Agency- Based Community Benefits providers as defined in the Centennial Care Managed Care Policy Manual and the New Mexico Administrative Code (NMAC). For your reference, the Policy Manual can be located at the following web address : https://www.hsd.state.nm.us/providers /managed-care-policy-manual/. The NMAC Program Rules can be located at the following web address: https://www.hsd.state.nm.us/providers/rules-nm-administrative-code/.

All elements of the audit are included under Section 8 of the Policy Manual and Section 8.320.2.18.c NMAC. Your contract with [MCO] and the Policy Manual require agencies to participate in and provide documentation for audit purposes. *Failure to submit complete documentation in a timely manner may result in correct actions, possibly up to and including contract termination.*

Please submit the follow documentation **within thirty (30) calendar days** from the date of this letter:

Attached you will find the Audit tool each MCO will be using to conduct this mandatory and yearly audit. We are required to request documentation specifically related to each service you are contracted for with [MCO]. Please reference the audit tool to see each item required for the audit related to:

(The Provider Types requiring audit with your agency will be listed here)

Please scan and email the requested documentation to: *(Specific MCO email address here)*

If you have any questions or concerns, please contact your Network Services Provider Representative (MCO CONTACT LIST) or you can contact us at *(Specific MCO email address here)*

Sincerely,

(MCO NAME HERE)

ABCB All MCO Document Request Form

ABCB Desk Audit for Calendar Year 2024

Document Request Form

Instructions

Please scan and email the requested documentation to the respective MCO.

Req. No.	Contract Citation	Requirement Question	Documentation Requested
Provider Requirements			
1	Section 8.10 page 200	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.	• Policy and Procedures (P&Ps) • Statement of Process (SOP) • Desk Level Procedure (DLP)
2	Section 8.10 page 201	The employment supports provider must be able to demonstrate it has a functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance.	• Online website that includes the list of service locations available to members • Member pamphlets/brochures • New hire documentation • Welcome packets for members
3	Section 8.10 page 201	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/Medical Assistance Division (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.	• P&Ps • SOP • DLP that documents the maintenance and archiving of employee documentation for the entirety of the caregiver's employment
4	Section 8.10 page 201	The provider shall maintain a confidential case file for each member and will include the following items: a. Quarterly progress reports; b. Vocational assessment or profile; and	• P&Ps • SOP • DLP

*This is an example of a document request form. This is not all inclusive.

Audit Submissions

- Providers are to submit the required documentation to the assigned MCO identified on the initial documentation request letter:
  - Blue Cross and Blue Shield: BCBSNM_HCBS_audits@bcbsnm.com
  - Molina: abcb_hcbsaudits@molinahealthcare.com
  - Presbyterian: HCBSAuditsPHP@phs.org
  - United Healthcare: uhcnmprovideraudits@uhc.com

You will be contacted by the assigned MCO if there are any questions and/or missing documentation.

Provider Resources

Managed Care Policy Manual

The purpose for the Managed Care Policy Manual is to provide a reference for the policies established by Health Care Authority (HCA) for the administration of the Medicaid managed care program and to provide direction to the Managed Care Organizations (MCOs) and other entities providing service under managed care.

This Manual should be used as a reference and a general guide. It is a resource for interpreting the Medicaid Managed Care Services Agreement (the Agreement) and New Mexico Administrative Code (NMAC) rules pertaining to managed care.

The Policy can be found here at: Managed Care Policy Manual

- Section 07 - Community Benefits
- Section 08 - Agency Based Community Benefits (ABCB)
- Section 09 - Self Directed Community Benefits (SDCB)

New Mexico Administrative Code (NMAC)

The New Mexico Administrative Code (NMAC) is the official collection of current rules (regulations) written and filed by state agencies to clarify and interpret laws passed by the legislature.

This can be found here at: Program Rules - New Mexico Health Care Authority

Helpful Sections for Providers:

Chapter 302 – Medicaid General

Chapter 308 – Managed Care Program

- NMAC 8.308.12 Community Benefits

Chapter 312 – Long Term Care Services / Nursing Services

Chapter 320 – Early and Periodic Screening, Diagnosis & Treatment Services (EPSDT)

MCO Newsletters

- MCO's will jointly develop and distribute an annual PCS letter.
- It can be accessed at the following website: Community Benefit Program - New Mexico Health Care Authority

MCO Trainings

- MCO will jointly develop and present bi-annual trainings for PCS providers
  - Training will be provided with in-person & virtual options
  - Recording of trainings will be made available to PCS providers
- Please plan to attend one of these required trainings:
- **Thursday, May 8 / Albuquerque:** 10 a.m. to 12 p.m.
  - Attend live at:
    James Hinton Auditorium – Presbyterian Cooper Center
    (provider parking available in the NE parking lot)
  - Register to attend online
- **Morning of Thursday, Sept. 4 / Las Cruces:** 9:30 to 11:30 a.m.
  - Attend live at:
    1320 South Solano Drive (main conference room)
  - Register to attend online
- **Afternoon of Thursday, Sept. 4 / Las Cruces:** 1 to 3 p.m.
  - Attend live at:
    1320 South Solano Drive (main conference room)
  - Register to attend online

Audit Requirements

MCO Requirement to Monitor Community Benefit Providers:

- MCOs are required to monitor the provision of all Community Benefits to ensure provider compliance with all applicable federal HCB settings requirements. The MCOs must conduct monitoring activities to ensure that all Community Benefit providers, including SDCB employees meet provider requirements per the Managed Care Policy Manual, including individual attendant/Caregiver requirements. The monitoring activities may not be delegated to the provider. *(Turquoise Care Contract 4.5.7.7)*
- The MCOs must perform annual audits of all contracted Agency-Based Community Benefit (ABCB) providers using an audit tool that is approved by HCA. The MCOs shall collaborate to develop an audit schedule that ensures that all ABCB providers are audited only once per calendar year. *(Turquoise Care Contract 4.5.7.7.1)*

PCS Agency 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.
- Personal Care Service agency requirements can be found in section 8.14 of the Managed Care Policy Manual

Annual PCS Audit Requirements

Agency Requirements: Current And Active Business Licenses

- 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.
  - Agencies are asked to supply the valid documentation to cover the timeframe being audited.

Agency Requirements: W9 or Documentation Supporting Tax Exempt status

- A copy of W-9 or other documentation supporting tax exemption status
    - Agencies are asked to supply the valid documentation to cover the timeframe being audited.

Agency Requirements: Current and Active Liability & Workers Compensation Liability

- Proof of liability and workers' compensation insurance
  - Agencies are asked to supply the valid documentation to cover the timeframe being audited.

Agency Requirements: Caregiver Onboarding and Screening Policy

Agency policy or procedure outlining agencies caregiver onboarding and screening process to include the following;

- **Nationwide criminal history screening** *(within 20 calendar days of hire) 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*
- **Annual verification that caregivers are not on the employee abuse registry** *Pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA 1978, Section 277A1 et seq.)*
- **Tuberculosis (TB) testing** *(follow current recommendations of DOH and CDC, as appropriate for preventing the transmission of TB)*
- **Hepatitis B immunizations** *(or waiver explaining the acceptance and consequences of such)*
- **Obtaining signed agreement that caregiver will not provide services while under the influence of drugs or alcohol** *(consequences resulting in immediate termination)*
- **Obtaining copies of caregivers current and valid State driver's license and current motor vehicle insurance policy** *(documents must be under the name of the caregiver)*

Agencies are required to verify the above prior to employment and annually thereafter.

Agency Requirements: Critical Incident Reporting & reporting of suspected Abuse, neglect and Exploitation

Agency policy or procedure outlining agencies Critical Incident Report (CIR) and reporting of suspected abuse, neglect and exploitation process.

All agencies in New Mexico providing HCBS and BH services are required to report Critical Incidents within 24 hours of knowledge of the occurrence. The critical incident(s) should be reported to the Member's MCO and/or Adult Protective Services (APS) or Child Protective Services (CPS) as necessary.

Agency Requirements: Regularly Scheduled and Back-up Attendants/Caregivers

Agency policy or procedure on how agency ensures trained, qualified attendants are available as backup for regularly scheduled attendants and for emergency situations.

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.

Agency Requirements: Face to Face Supervisory Visits in Consumer Residence (Consumer Delegated Agencies Only)

Agency policy or procedure on how agency monitors and conducts face-to-face supervisory visits and the form that is used to document the supervisory visit.

Consumer Delegated Agencies are required to conduct 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
- Signature of consumer or consumer's legal representative

Agency Requirements: Face to Face Supervisory Visits in Consumer Residence (Consumer Delegated Agencies) cont.

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.

Agency Requirements: Individual Plan of Care (IPoC) (Consumer Delegated Agencies)

Agency policy or procedure on how agency develop the clients IPoC based on the assessment, service authorization task list and consideration of natural supports.

- 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.

Agency Requirements: Electronic Visit Verification (EVV)

Agency policy or procedure on how agency provides oversight of employees to ensure the required use of the Electronic Visit Verification (EVV) system.

Agencies are to also provide a copy of the EVV training and attendance records.

- 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. For SDCB, EVV will be implemented according to federal requirements and timelines.
- 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.
    - All caregivers, assigned and substitute, should be trained in EVV.

Agency Requirements: PCS Agency Office Requirements

Agency policy or procedure on how agency provides services in all required/approved counties and maintains an official office for conducting business with phone number and hours of operation.

All certified PCS agencies are required to select a county in which to establish and maintain an official office for conducting of business with published phone number and hours of operation; the PCS agency must provide services in all areas of the county in which the main office is located. Upon HCA approval, the PCS agency may elect to serve any county within 100 miles of the main office. The PCS agency may elect to establish branch office(s) within 100 miles of the main office. The PCS agency must provide PCS services to all areas of all selected counties

Agency Requirements: Staffing of Caregivers

Agency policy or procedure on how agency monitors onboarding of new clients that are unable to be staffed by caregivers.

- What is the timeline to engage the members care coordinator/member in potentially selecting a new agency?
- What do agencies have in place to recruit and retain caregivers?

Caregiver/Attendant Trainings

Documentation of Annual Caregiver Training: Consumer Delegated Model

Agencies are to document all trainings completed annually. Consumer Delegated caregivers are required to complete12 hours of training annually.

Agencies are to submit documentation listing (spreadsheet) of annual trainings completed, to include the following;

- Names of caregivers trained
- Title or type of trainings
- Source of trainings (in person, web-based, self lead etc.)
- Number of hours (total number of hours for each training)
- Dates of trainings
- Competency test date and score for each caregiver (**passing score = 80% and is to be completed within the first 3 months of employment**)
- CPR Certification date (must be current)
- First Aid Certification date (must be current)
- Caregiver's drivers license expiration date (or note if caregiver will not be doing any driving related activities)
- Caregiver's motor vehicle insurance policy (date of monthly verification by agency)
  - **Insurance Policy must list caregiver name as covered**

Annual Caregiver Training Materials: Consumer Delegated Model

Agencies are to submit copies of all annual caregiver training and orientation materials (one copy of each).

- Overview of PCS
- Living with a disability or chronic illness in the community
- CPR, First-Aid Training
- Education from the Centers for Disease Control and Prevention (CDC) recommendations (offering Hepatitis B immunization at time of employment)
- Competency Test

Documentation of Annual Caregiver Training: Consumer Directed Model

Consumer Directed agencies are to submit a documented listing(spreadsheet) of all consumer signed agreements during the timeframe being audited. Documentation shall include the following;

- Name of consumer
- Date agreement signed/completed

Consumer Directed agencies are to maintain a copy of the signed agreement in the consumer's file. By this agreement, the consumer is accepting responsibility for all aspects of care and training, including mandatory training:

- 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.

Agency Requirements: Competency Test for Caregivers

PCS agencies may purchase a competency test or develop their own.

Attendants must successfully pass a written personal care attendant competency test with an 80% within the first three months of employment;

- Agencies must document date, method used to determine competency, and a copy of the attendant's graded 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.

Competency Test (must include 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
- Confidentiality

(EPSDT) PCS Providers: Additional Requirements

Agencies are to submit a policy (or other documentation) that addresses PCS attendant(s) to the medical assistance program (MAP)-eligible recipient must be supervised by a medical assistance division (MAD)-enrolled RN and verifies that the supervisory RN must be employed or contracted by the PCS agency and have one-year direct patient care experience.

The supervisory RN is responsible for conducting and documenting visits at the MAP eligible recipient's residence for the purpose of assessing his or her progress and the PCS attendant's performance. The ITP should be updated as indicated and in cooperation with the MAP eligible recipient's case manager. These visits will be conducted and documented every 62 calendar days or more often if the MAP eligible recipient's condition warrants it.

Additional information on this requirement can be found in NMAC Section 8.320.2.18.C

Final Tips & Takeaways