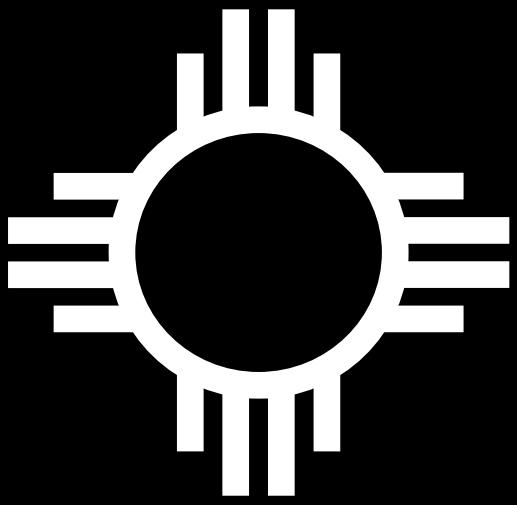
NEW MEXICO REGISTER



Volume XXII
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March 31, 2011

New Mexico Register

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The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2011

New Mexico Register

Volume XXII, Number 6
March 31, 2011

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Effective Date and Validity of Rule Filings

Rules published in this issue of the New Mexico Register are effective on the publication date of this issue unless otherwise specified. "No rule shall be valid or enforceable until it is filed with the records center and published in the New Mexico register as provided by the State Rules Act. Unless a later date is otherwise provided by law, the effective date of a rule shall be the date of publication in the New Mexico register." Section 14-4-5 NMSA 1978.

A=***Amended***, E=***Emergency***, N=***New***, R=***Repealed***, Rn=***Renumbered***

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Notices of Rulemaking and Proposed Rules

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD
NOTICE OF HEARING

On May 11, 2011, at 5:30 PM, the Albuquerque-Bernalillo County Air Quality Control Board (Air Board) will hold a public hearing in the Vincent E. Griego Chambers located in the basement level of the Albuquerque-Bernalillo County Government Center, One Civic Plaza NW, Albuquerque, NM. The hearing will address:

Proposal to adopt amendments to 20.11.100 NMAC, *Motor Vehicle Inspection - Decentralized*, and to incorporate an amended 20.11.100 NMAC into the New Mexico State Implementation Plan (SIP) for air quality.

The Environmental Health Department of the City of Albuquerque, by and through the Vehicle Pollution Management Division (VPMD) operates a decentralized vehicle emissions testing program as required by the federal Clean Air Act and enforced by the Environmental Protection Agency (EPA). (Code of Federal Regulations, Environmental Protection Agency, Subpart S, *Inspection/Maintenance Program Requirements.* (I/M program), 40 CFR § 51.350 to 51.390). The Inspection and Maintenance Program outlined in 20.11.100 NMAC is one of the key local control strategies designed and implemented to prevent a violation of the National Ambient Air Quality Standards (NAAQS) for carbon monoxide, ground level ozone and inhalable particulates. 20.11.100 NMAC was last amended in 2004 and incorporates as law the *Albuquerque/ Bernalillo County Vehicle Pollution Management Program Procedures Manual* which contains numerous references to obsolete equipment and procedures. After reviewing these two documents, VPMD determined that the most efficient approach to achieving a more functional and logical 20.11.100 was to restructure and amend the existing regulation. In particular, the proposed amendments do the following:

1. Maintains large amounts of original language but revises the regulation's structure to make it easier to read and understand and removes several redundant sections;

2. Amends the regulation to better define the new motor vehicle exemption period as 4 years rather than 2 registration cycles, exempts vehicles thirty-five years or older consistent with the state collector car provisions, allows for the limited use of mobile test units for the on-site testing of 1996 and newer fleet and dealer lot vehicles, returns 1975 – 1985 model year vehicles from annual to biennial testing, requires testing of hybrid vehicles if purchased after the effective date of the amended regulation or upon change of ownership, provides for the testing of diesel vehicles beginning January 1st of the year following the adoption of a more stringent ozone standard by EPA, and removes the $300 repair cost threshold for time extensions for individuals on public assistance;

3. Moves the enforcement and appeal sections from the Procedures Manual to 20.11.100 NMAC and changes the Procedures Manual from a regulatory document to a technical guidance document.

Following the hearing, the Air Board will hold its regular monthly meeting during which the Air Board is expected to consider adopting the proposed amendments and incorporating the amended regulation into the SIP. Meetings of the Air Board are open to the public and all interested persons are encouraged to participate. All persons who wish to testify regarding the subject of the hearing may do so at the hearing and will be given a reasonable opportunity to submit relevant evidence, data, views, and arguments, orally or in writing, to introduce exhibits and to examine witnesses in accordance with the Joint Air Quality Control Board Ordinances, Section 9-5-1-6 ROA 1994 and Bernalillo County Ordinance 94-5, Section 6, and 20.11.82 NMAC, *Rulemaking Procedures -- Air Quality Control Board*.

Anyone intending to present technical testimony at this hearing is required by 20.11.82.20 NMAC to submit a written Notice Of Intent to testify (NOI) before 5:00pm on April 26, 2011, to: "Attn: Neal Butt, Albuquerque Environmental Health Department, P.O. Box 1293, Albuquerque, NM 87103", or to deliver the NOI to the Environmental Health Department, Suite 3023, 3rd Floor, One Civic Plaza (400 Marquette Avenue NW), Albuquerque, NM 87102. The NOI shall: 1. identify the person for whom the witness or witnesses will testify; 2. identify each technical witness the person intends to present and state the qualifications of that witness, including a description of their educational and work background; 3. summarize or include a copy of the direct testimony of each technical witness and state the anticipated duration of the testimony of that witness; 4. include the text of any recommended modifications to the proposed regulatory change; and 5. list and describe, or attach, all exhibits anticipated to be offered by that person at the hearing, including any proposed statement of reasons for adoption of rules.

In addition, written comments to be incorporated into the public record for this hearing should be received at the above P.O. Box, or Environmental Health Department office, before 5:00 pm on May 4, 2011. Comments shall include the name and address of the individual or organization submitting the statement. Written comments may also be submitted electronically to nbutt@cabq.gov and shall include the required name and address information. Interested persons may obtain a copy of the proposed regulation at the Environmental Health Department office, or by contacting Neal Butt electronically at nbutt@cabq.gov or by phone (505) 768-2660, or by downloading a copy from the City of Albuquerque Air Quality Division website http://www.cabq.gov/airquality/aqcb/public-review-drafts .

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ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD
NOTICE OF HEARING

On June 8, 2011, at 5:30 PM, the Albuquerque-Bernalillo County Air Quality Control Board (Air Board) will hold a public hearing in the Vincent E. Griego Chambers located in the basement level of the Albuquerque-Bernalillo County Government Center, One Civic Plaza NW, Albuquerque, NM. The hearing will address:

Proposal to adopt amendments to the *Section 309 Regional Haze State Implementation Plan Element: Albuquerque - Bernalillo*

County, New Mexico, and submit said amendments to U.S. Environmental Protection Agency (EPA) as a revision to the New Mexico State Implementation Plan (SIP) for air quality.

The *Section 309 Regional Haze State Implementation Plan Element: Albuquerque - Bernalillo County, New Mexico*, was first submitted pursuant to the U.S. Environmental Protection Agency (EPA) requirements published in the Federal Register [FR Vol. 64, No. 126] on Thursday, July 1, 1999. This Regional Haze State Implementation Plan (SIP) addressed requirements found in 40 CFR Part 51, Appendix V relating to completeness of SIP submissions. This SIP was first presented before the Albuquerque-Bernalillo County Air Quality Control Board (Air Board) at a public hearing held on October 8, 2003 and continued on November 12, 2003. Appropriate public notices and opportunities for public comment were provided. The Air Board adopted the initial Regional Haze SIP on November 12, 2003.

Since the regulation to address the type of visibility impairment known as 'Regional Haze' was first promulgated by EPA in 1999, it has been judicially challenged twice. On May 24, 2002, the U.S. Court of Appeals for the District of Columbia Circuit issued a ruling vacating the Regional Haze Rule in part and sustaining it in part, based on a finding that EPA's prescribed methods for determining best available retrofit technology (BART) were inconsistent with the Clean Air Act (CAA) [American Corn Growers Association v. EPA, {291 F.3d 1 (DC Cir. 2002)}]. EPA finalized a rule on July 6, 2005 addressing the court's ruling in this case [FR Vol. 70 No. 128 39104-39172]. On February 18, 2005, the U.S. Court of Appeals for the District of Columbia Circuit issued another ruling, in Center for Energy and Economic Development (CEED) v. EPA, [398 F.3d 653(DC Cir. 2005)], granting a petition challenging provisions of the Regional Haze Rule governing an optional emissions trading program for certain western States and Tribes [the Western Regional Air Partnership (WRAP) Annex Rule]. EPA published proposed regulations to revise the provisions of the Regional Haze Rule governing alternative trading programs, and to provide additional guidance on such programs in August 2005. EPA received several comments on the August 2005 proposal. This final rule [Federal Register: October 13, 2006 (Volume 71, Number 198)] finalized the proposed revisions, including changes in response to the public comments. This rule became effective December 12, 2006. The Regional Haze SIP was amended to address all these actions, as well as addressing comments received from EPA on 11/3/04, and in 2007. The Air Board adopted this revised Regional Haze SIP on August 13, 2008.

In 2010 EPA Region 6 conveyed to New Mexico and Albuquerque-Bernalillo County that there were certain technical issues concerning the $S0_2$ trading program in New Mexico's Regional Haze SIP that remained to be resolved. EPA Regions 6, 8, and 9 (the "Regions") had reviewed the document entitled *Demonstration that the $S0_2$ Milestones Provide Greater Reasonable Progress than BART dated July 23, 2009*. This document illustrated the position held by the States participating in the Regional Haze option under 40 CFR 51.309 (the 309 SIPs), that a 2018 $S0_2$ milestone of 234,624 tons $S0_2$ satisfied the requirements under Section 51.309(d)(4), and specifically, that the 2018 milestone will achieve greater reasonable progress than would have been achieved from the installation and operation of Best Available Retrofit Technology (BART). However, the Regions determined that based on their review, the proposed 2018 milestone did *not* satisfy Section 51.309(d)(4). Therefore, in order to approve the Regional Haze SIP for the aforementioned states, EPA has asked that the proposed milestones be revised in order to meet the requirements of Section 51.309(d)(4). To this end, the States and the Regions have negotiated a revised set of milestones. These revised milestones and their associated changes have been incorporated into this third iteration of the Regional Haze SIP, labeled Public Review Draft, 2/22/2011. In addition, since this SIP was last amended, the state of Arizona has changed from a "309" program to a "308" program, and so this change has been also noted in this SIP.

Summary of Changes from the 2003 SIP

* Arizona and Oregon are no longer participating in the trading program and are instead focusing resources on developing a single SIP under section 308 of the regional haze rule. The trading program was designed to accommodate these changes and the milestone has been reduced to reflect the smaller number of sources in the program.

* The base year for the milestones was updated to the year 2006, and emission reductions between 2006 and 2010 have been included for individual plants, effectively locking in the substantial emission reductions that have occurred since the Annex was finalized in 2000.

* New source growth estimates for utilities have been reduced substantially to account for changing projections for new coal-fired power plants in the region. Coal will continue to be an important resource in the region, but new renewable energy resources and efforts to improve efficiency have reduced projections for new plants in the region. New plants will use state of the art emission reduction technologies with significantly lower SO_2 emissions than older facilities. The new source growth estimate has been reduced to 2,600 tons of SO_2 for new plants in the region by 2018.

* All power plants that are subject to BART are assumed to meet the presumptive BART emission rate of 0.15 lb/MMBtu. This assumption is appropriate because the trading program was designed to achieve reasonable progress from all stationary sources of SO_2, with BART as a secondary goal.

* After seven successful years of implementing the program, there is greater certainty about regional emissions. Therefore the headroom/uncertainty factor is no longer needed.

* A tribal set-aside of 2,500 allowances is included in the program. This set-aside is "below the line" and is available as a special allocation if the program is triggered.

* When the Annex to the Grand Canyon Visibility Transport Commission Recommendations was finalized in 2000, additional incentives were needed to encourage zero emission technologies. Since that time there has been tremendous growth in renewable portfolio standards. GHG regulations are further encouraging renewable energy. The renewable energy credit is no longer included in the program because these other incentives are achieving the goal.

The proposed 2018 milestone represents a 60% reduction in SO_2 emissions since 1990 in the 3-state region. Substantial improvement can be seen in the sulfate contribution to visibility in the Class I areas along the Colorado Plateau. The improvement is especially apparent on the cleanest days that are not impacted by emissions from wildfires.

Following the hearing, the Air Board will hold its regular monthly meeting during which the Air Board is expected to consider adopting the aforementioned proposed amendments. Meetings of the Air Board are open to the public and all interested persons are encouraged to participate. All persons who wish to testify regarding the subject of the hearing may do so at the hearing and will be given a reasonable opportunity to submit relevant evidence, data, views, and arguments, orally or in writing, to introduce exhibits and to examine witnesses in accordance with the Joint Air Quality Control

Board Ordinances, Section 9-5-1-6 ROA 1994 and Bernalillo County Ordinance 94-5, Section 6, and 20.11.82 NMAC, *Rulemaking Procedures -- Air Quality Control Board*.

Anyone intending to present technical testimony at this hearing is required by 20.11.82.20 NMAC to submit a written Notice Of Intent to testify (NOI) before 5:00pm on May 24, 2011, to: "Attn: Neal Butt, Albuquerque Environmental Health Department, P.O. Box 1293, Albuquerque, NM 87103", or to deliver the NOI to the Environmental Health Department, Suite 3023, 3rd Floor, One Civic Plaza (400 Marquette Avenue NW), Albuquerque, NM 87102. The NOI shall: 1. identify the person for whom the witness or witnesses will testify; 2. identify each technical witness the person intends to present and state the qualifications of that witness, including a description of their educational and work background; 3. summarize or include a copy of the direct testimony of each technical witness and state the anticipated duration of the testimony of that witness; 4. include the text of any recommended modifications to the proposed regulatory change; and 5. list and describe, or attach, all exhibits anticipated to be offered by that person at the hearing, including any proposed statement of reasons for adoption of rules.

In addition, written comments to be incorporated into the public record for this hearing should be received at the above P.O. Box, or Environmental Health Department office, before 5:00 pm on June 1, 2011. Comments shall include the name and address of the individual or organization submitting the statement. Written comments may also be submitted electronically to nbutt@cabq.gov and shall include the required name and address information. Interested persons may obtain a copy of the proposed regulation at the Environmental Health Department office, or by contacting Mr. Neal Butt electronically at nbutt@caqb.gov or by phone (505) 768-2660, or by downloading a copy from the City of Albuquerque Air Quality Division website http://www.cabq.gov/airquality/aqcb/public-review-drafts .

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NEW MEXICO CHILDREN, YOUTH AND FAMILIES DEPARTMENT

ADMINISTRATIVE SERVICES DIVISION

NOTICE OF PUBLIC HEARING

The Children, Youth and Families Department, Administrative Services, will hold a formal public hearing on Wednesday, May 4, 2011, at 3:00 p.m. in Room 565 of the PERA Building, 1120 Paseo de Peralta, Santa Fe, New Mexico to receive public comment regarding proposed amendments to 8.8.3 NMAC Governing Background Checks and Employment History Verification. The proposed amendments may be obtained by contacting Mary J. Gutierrez at 505-827-7326.

Interested persons may testify at the hearing or submit written comments no later than 5:00 p.m. on May 4, 2011. Written comments will be given the same consideration as oral testimony given at the hearing. Written comments should be addressed to: Mary J. Gutierrez, Administrative Services Background Check Unit, Children, Youth and Families Department, P.O. Drawer 5160, Santa Fe, New Mexico 87502-5160, Fax Number: 505-827-7422, Electronic Mail: Mary.Gutierrez1@state.nm.us.

If you are a person with a disability and you require this information in an alternative format or require special accommodations to participate in the public hearing, please contact Mary J. Gutierrez at 505-827-7326. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD
NOTICE OF STATE IMPLEMENTATION PLAN AND RULEMAKING HEARING

The New Mexico Environmental Improvement Board ("Board") will hold a public hearing on June 1, 2011 at 9:00 a.m. in Room 307 at the State Capitol Building (Roundhouse), 490 Old Santa Fe Trail, Santa Fe, New Mexico, continuing on June 2 and, if necessary, June 3 and 4, 2011 in Farmington, New Mexico at San Juan College, 4601 College Blvd. The New Mexico Environment Department ("NMED") is proposing to adopt revisions to the New Mexico State Implementation Plan for Regional Haze. The proposed plan establishes requirements for New Mexico to meet the requirements of 40 CFR Section 51.309, including a determination of Best Available Retrofit Technology for nitrogen oxides and particulate matter for the San Juan Generating Station. Revisions to 20.2.73 NMAC and 20.2.81 NMAC are also proposed.

The proponent of this regulatory adoption and revision is the New Mexico Environment Department ("NMED").

The purpose of the public hearing is to consider and take possible action on a petition from NMED regarding revisions to New Mexico's State Implementation Plan under the federal regional haze rule, 40 CFR Section 51.309. The regional haze rule requires states to submit State Implementation Plans to address visibility impairment caused by regional haze in 156 federally-protected parks and wilderness areas, known as Class I areas, including nine such areas in New Mexico. Revisions to 20.2.73 NMAC and 20.2.81 NMAC are also proposed to conform those rules to federal requirements for the regional haze program.

The proposed revised regulations and plan may be reviewed during regular business hours at the NMED Air Quality Bureau office, 1301 Siler Road, Building B, Santa Fe, New Mexico. The full text of NMED's proposed revised State Implementation Plan and regulations are available on NMED's web site at www.nmenv.state.nm.us, or by contacting Rita Bates at (505) 476-4304 or by email at rita.bates@state.nm.us.

The hearing will be conducted in accordance with 20.1.1 NMAC (Rulemaking Procedures – Environmental Improvement Board), the Environmental Improvement Act, Section 74-1-9 NMSA 1978, the Air Quality Control Act, Section 74-2-6 NMSA 1978, and other applicable procedures.

All interested persons will be given reasonable opportunity at the hearing to submit relevant evidence, data, views and arguments, orally or in writing, to introduce exhibits, and to examine witnesses. Persons wishing to present technical testimony must file with the Board a written notice of intent to do so. The notice of intent shall:

(1) identify the person for whom the witness(es) will testify;
(2) identify each technical witness that the person intends to present and state the qualifications of the witness, including a description of their education and work background;
(3) include a copy of the direct testimony

in narrative form of each technical witness and state the anticipated duration of the testimony of that witness;
(4) attach each exhibit anticipated to be offered by that person at the hearing; and
(5) attach the text of any recommended modifications to the proposed new and revised regulations.

Notices of intent for the hearing must be received in the Office of the Board not later than 5:00 pm on May 17, 2011, and should reference the docket number, EIB 11-01 (R), and the date of the hearing. Notices of intent to present technical testimony should be submitted to:

Felicia Orth, Acting Board Administrator
Office of the Environmental Improvement Board
Harold Runnels Building
1190 St. Francis Dr., Room 2150-N
Santa Fe, NM 87502
Phone: (505) 827-0339, Fax (505) 827-2836

Any member of the general public may testify at the hearing. No prior notification is required to present non-technical testimony at the hearing. Any such member may also offer exhibits in connection with his testimony, so long as the exhibit is not unduly repetitious of the testimony.

A member of the general public who wishes to submit a written statement for the record, in lieu of providing oral testimony at the hearing, shall file the written statement prior to the hearing, or submit it at the hearing.

Persons having a disability and needing help in being a part of this hearing process should contact Judy Bentley by May 17, 2011 at the NMED, Personnel Services Bureau, P.O. Box 5469, 1190 St. Francis Drive, Santa Fe, New Mexico, 87502-5469, telephone 505-827-9872. TDY users please access her number via the New Mexico Relay Network at 1-800-659-8331.

The Board may make a decision on the proposed revised state implementation plan and regulations at the conclusion of the hearing, or the Board may convene a meeting at a later date to consider action on the proposal.

NEW MEXICO DEPARTMENT OF HEALTH

NOTICE OF PUBLIC HEARING

The New Mexico Department of Health will hold a public hearing on 7.4.7 NMAC "Human Immunodeficiency Virus Partner Service." The Hearing will be held on Friday, April 8, 2011 beginning at 9:30 a.m. in the Harold Runnels Building Auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico.

The public hearing will be conducted to receive public comment regarding proposed promulgated rules.

A copy of the proposed rules can be obtained by requesting by email from:

Andrew A. Gans, MPH
HIV Prevention Program Manager
New Mexico Department of Health
andrew.gans@state.nm.us

Please submit any written comments regarding the proposed rules to Mr. Gans at the email address listed above.

The Department will accept public comment through the close of the hearing unless otherwise specified.

If you are an individual with a disability who is in need of special assistance or accommodations to attend or participate in the hearing, please contact Christina Galvez at the above address or telephone number. The Department requests at least ten (10) days advance notice for special accommodations requests.

End of Notices and Proposed Rules Section

Adopted Rules

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

8.314.6 NMAC, Mi Via Home and Community Based Services Waiver filed 11-16-2006 is repealed and replaced by 8.314.6 NMAC, Mi Via Home and Community Based Services Waiver, effective 4-1-2011.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 6 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.6.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.314.6.1 NMAC - Rp, 8.314.6.1 NMAC, 4-1-11]

8.314.6.2 SCOPE: The rule applies to the general public.
[8.314.6.2 NMAC - Rp, 8.314.6.2 NMAC, 4-1-11]

8.314.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, Sections 27-2-12 et seq.
[8.314.6.3 NMAC - Rp, 8.314.6.3 NMAC, 4-1-11]

8.314.6.4 DURATION: Permanent.
[8.314.6.4 NMAC - Rp, 8.314.6.4 NMAC, 4-1-11]

8.314.6.5 EFFECTIVE DATE: April 1, 2011, unless a later date is cited at the end of a section.
[8.314.6.5 NMAC - Rp, 8.314.6.5 NMAC, 4-1-11]

8.314.6.6 OBJECTIVE: The objective of this rule is to provide rules for the service portion of the New Mexico medicaid program. This rule describes eligible providers, eligible participants, covered services, non-covered services, utilization review, and provider reimbursement.
[8.314.6.6 NMAC - Rp, 8.314.6.6 NMAC, 4-1-11]

8.314.6.7 DEFINITIONS:

A. **AIDS waiver:** A medicaid home and community-based services (HCBS) waiver program for recipients who are diagnosed as having acquired immunodeficiency syndrome (AIDS) or AIDS-related conditions and who meet the level of care provided in a nursing facility (NF).

B. **Authorized agent:** The participant may choose to appoint an authorized agent designated to have access to medical and financial information for the purpose of offering support and assisting the participant in understanding waiver services. The participant will designate a person to act as an authorized agent by signing a release of information form indicating the participant's consent to the release of confidential information. The authorized agent will not have the authority to direct mi via waiver services. Directing services remains the sole responsibility of the participant or his/her legal representative. The participant's authorized agent does not need a legal relationship with the participant. While the participant's authorized agent can be a service provider for the participant, the authorized agent cannot serve as the participant's consultant. If the authorized agent is an employee, he/she cannot sign his/her own timesheet.

C. **Authorized annual budget (AAB):** The actual amount of the annual budget approved for a participant by the TPA. Participants work with their consultant to develop an annual budget request, which is submitted to the TPA for review and approval. The total amount approved by the TPA is the authorized annual budget (AAB).

D. **Brain injury (BI):** Individuals (through age 65) with an injury to the brain of traumatic or acquired origin resulting in a total or partial functional disability or psychosocial impairment or both. The BI participant must have a documented BI diagnosis, as included in the international classification of diseases 9th revision clinical modification (ICD 9-CM) codes which are attached to this part of the NMAC as attachment I.

E. **Category of eligibility (COE):** To qualify for medicaid, a person must meet financial criteria and belong to one of the groups that the state has defined as eligible. All participants in mi via must belong to one of the categories of eligibility (COE) described in 8.314.6.13 NMAC.

F. **Centers for medicare and medicaid services (CMS):** Federal agency within the United States department of health and human services that works in partnership with the states to administer medicaid.

G. **Consultant provider:** May be an agency or an individual. Provides consultant and support guide services to mi via participants that assist the participant (or the participant's family or legal representative, as appropriate) in arranging for, directing and managing mi via services and supports, as well as developing, implementing and monitoring the service and support plan (SSP) and AAB.

H. **Employer of record (EOR):** The employer of record (EOR) is the individual responsible for directing the work of mi via employees, including recruiting, hiring, managing and terminating all employees. The EOR tracks expenditures for employee payroll, goods, and services. EORs authorize the payment of timesheets by the financial management agency (FMA). A participant may be his/her own EOR unless the participant is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. Participants may also designate an individual of their choice to serve as their EOR, subject to the EOR meeting the qualifications specified in these regulations.

I. **Financial management agency (FMA):** Contractor that helps implement the AAB by paying the participant's service providers and tracking expenses.

J. **Home and community-based services (HCBS) waiver:** Medicaid program that provides alternatives to long-term care services in institutional settings. The federal government waives certain statutory requirements of the Social Security Act to allow states to provide an array of community-based options through these waiver programs.

K. **Individual budgetary allotment (IBA):** The maximum budget allotment available to an individual participant, determined by his/her established level of care (LOC) and category of eligibility. Based on this maximum amount, the participant will develop a plan to meet his/her assessed functional, medical and habilitative needs to enable the participant to remain in the community.

L. **Intermediate care facilities for the mentally retarded (ICF/MR):** Facilities that are licensed and certified by the New Mexico department of health (DOH) to provide room and board, continuous active treatment and other services for eligible medicaid recipients with a primary diagnosis of mental retardation.

M. **Legal representative:**

A person that is a legal guardian, conservator, power of attorney or otherwise has a court established legal relationship with the participant. The participant must provide certified documentation to the consultant provider and FMA of the legal status of the representative and such documentation will become part of the participant's file. The legal representative will have access to participant medical and financial information to the extent authorized in the official court documents.

N. **Legally responsible individual (LRI):** A legally responsible individual (LRI) 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. **Level of care (LOC):** The level of care (LOC) required by an individual in an institution. Participants in the mi via program must be determined to need either the LOC required for admittance to a licensed nursing facility (NF) or an ICF/MR.

P. **Mi via:** Mi via is the name of the Section 1915 (c) medicaid self-directed HCBS waiver program through which eligible participants have the option to access services to allow them to remain in the community.

Q. **Participant:** Individuals meeting the financial and medical LOC criteria who are approved to receive services through the mi via program.

R. **Reconsideration:** Participants who disagree with a clinical/medical utilization review decision or action may submit a written request through a consultant to the third party assessor (TPA) for a re-consideration of the decision.

S. **Self-direction:** Process applied to the service delivery system wherein participants identify, access and manage the services they obtain (among the state-determined waiver services and goods) to meet their personal assistance and other health-related needs.

T. **Service and support plan (SSP):** Participant plan that includes waiver services that meet the participant's needs to include the projected amount, frequency and duration of the services; the type of provider who will furnish each service; other services that the participant will access; and the participant's available supports that will complement waiver services in meeting his/her needs.

U. **State or state agency:** The mi via waiver program is managed and administered by three state agencies, the aging and long term services department (ALTSD), the department of health (DOH), and the human services department, medical assistance division (HSD/MAD). References to the "state" or "state agency" means these three agencies or other specifically indicated agency as appropriate.

V. **Support guide:** A function of the consultant provider that directly assists the participant in implementing the SSP to ensure access to mi via services and supports and to enhance success with self-direction. Support guide services provide assistance to the participant with employer/vendor functions or with other aspects of implementing his/her SSP.

W. **Third-party assessor (TPA):** The contractor that determines and re-determines LOC and medical eligibility for mi via services. The TPA also reviews each participant's SSP and approves an AAB for each participant. The TPA performs utilization management duties of all waiver services.

X. **Waiver:** A program in which the federal government has waived certain statutory requirements of the Social Security Act to allow states to provide an array of home and community-based service options through medicaid as an alternative to providing long-term care services in an institutional setting.

[8.314.6.7 NMAC - N, 4-1-11]

8.314.6.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.

[8.314.6.8 NMAC - Rp, 8.314.6.8 NMAC, 4-1-11]

8.314.6.9 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER:

A. Mi via, New Mexico's self-directed waiver program (mi via), is intended to provide a community-based alternative to institutional care that allows eligible participants to have control over services and supports. Mi via provides self-directed home and community-based services to eligible recipients, hereafter referred to as participants, who are living with disabilities (CoLTS (c)), conditions associated with aging (CoLTS (c)), certain traumatic or acquired brain injuries (BI), acquired immunodeficiency syndrome (AIDS), developmental disabilities (DD), or medically fragile conditions (MF). (See 42 CFR 441.300.)

B. Mi via is comprised of two medicaid home and community-based waivers established under Section 1915(c) of the Social Security Act. One waiver is specifically for eligible individuals who meet the LOC otherwise provided in a nursing facility (NF). The second waiver is specifically for eligible individuals who meet the LOC otherwise provided in an ICF/MR. Both waivers are managed as a single self-directed program and are administered collaboratively by the ALTSD, DOH, and HSD/MAD.

(1) The ALTSD is responsible for the daily administration of mi via for eligible individuals living with disabilities, conditions associated with aging, and certain traumatic or acquired brain injuries who meet the LOC for admittance to an NF. The DOH is responsible for the daily administration of mi via for eligible individuals living with developmental disabilities and medically fragile conditions who meet the LOC for admittance to an ICF/MR The DOH also manages the waiver for individuals living with AIDS who meet the LOC for admittance to an NF.

(2) Enrollment in mi via is limited to the number of federally authorized unduplicated participants and funding appropriated by the New Mexico legislature for this purpose.

[8.314.6.9 NMAC - Rp, 8.314.6.9 NMAC, 4-1-11]

8.314.6.10 MI VIA CONTRACTED ENTITIES AND PROVIDERS SUPPORTING SELF-DIRECTED SERVICES: The following resources and services have been established to assist participants to self-direct services. These include the following.

A. **Consultant services:** Consultant services are direct services intended to educate, guide and assist the participant to make informed planning decisions about services and supports, to develop a service and support plan (SSP) that is based on the participant's assessed needs and to assist the participant with quality assurance related to the SSP and AAB.

B. **Third-party assessor:** The TPA or HSD/MAD's designee is responsible for determining medical eligibility through an LOC assessment, assigning the applicable individual budgetary allotment (IBA), approving the SSP and authorizing a participant's annual budget in accordance with mi via regulations. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.6.13 NMAC; LOC determinations are done initially for individuals who are newly allocated to the waiver and at least annually for currently enrolled mi via participants; the LOC assessment is done in person with the participant in his/her home, an agreed upon location or in an inpatient setting; the TPA may re-evaluate the LOC more often than annually if there is an indication that the participant's condition or LOC has changed;

(2) applies the information from the LOC documentation and the following assessments, long-term care assessment

abstract (NF or ICF/MR), the comprehensive individual assessment (CIA), the universal assessment tool (UAT), or other state approved assessment tools, as appropriate for the category of eligibility, to assign the IBA for participants that are medically eligible; and

(3) reviews and approves the SSP and the annual budget request resulting in an AAB, at least annually or more often if there is a change in the participant's circumstances in accordance with mi via regulations.

C. **Financial management agent:** The FMA acts as the intermediary between the participant and the medicaid payment system and assists the participant or the EOR with employer-related responsibilities. The FMA pays employees and vendors based upon an approved SSP and AAB. The FMA assures participant and program compliance with state and federal employment requirements, monitors, and makes available to participants and the state reports related to utilization of services and budget expenditures. Based on the mi via participant's individual approved SSP and AAB, the FMA must:

(1) verify that mi via participants are eligible for medicaid prior to making payment for services;

(2) receive and verify that all required employee and vendor documentation and qualifications are in compliance with the mi via regulations;

(3) establish an accounting for each participant's AAB;

(4) process and pay invoices for goods, services, and supports approved in the SSP and the AAB and supported by required documentation;

(5) process all payroll functions on behalf of participants and EORs including:

(a) collect and process timesheets of employees;

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

(c) track and report disbursements and balances of the participant's AAB and provide a monthly report of expenditures and budget status to the participant and his/her consultant and quarterly and annual documentation of expenditures to the state;

(6) receive and verify provider agreements, including collecting required provider qualifications;

(7) monitor hours billed for services provided by the LRI and the total amounts billed for all goods and services during the month;

(8) answer inquiries from participants and solve problems related to the FMA's responsibilities; and

(9) report any concerns related to the health and safety of a participant or that the participant is not following the approved SSP and AAB to the consultant provider, HSD/MAD, and ALTSD or DOH, as appropriate.

[8.314.6.10 NMAC - Rp, 8.314.6.10 NMAC, 4-1-11]

8.314.6.11 QUALIFICATIONS FOR ELIGIBLE INDIVIDUAL EMPLOYEES, INDEPENDENT PROVIDERS, PROVIDER AGENCIES, AND VENDORS:

A. **Requirements for individual employees, independent providers, provider agencies and vendors:** In order to be approved as an individual employee, an independent provider, including non-licensed homemaker/companion workers, a provider agency (excluding consultant providers which are covered in a different subsection) or a vendor, including those that provide professional services, each entity must meet the general and service specific qualifications set forth in these regulations and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. In order to be an authorized provider for mi via and receive payment for delivered services, the provider must complete and sign an employee or vendor provider agreement and all required tax documents. The provider must have credentials verified by the participant/EOR and the FMA. In order to be an authorized consultant provider for the mi via program, the provider must have an approved provider agreement executed by the DOH/developmental disabilities supports division (DDSD) and HSD/MAD.

B. **General qualifications:**

(1) Individual employees, independent providers, including non-licensed homemaker/companion workers and provider agencies (excluding consultant providers) who are employed by a mi via participant to provide direct services shall:

(a) be at least 18 years of age;

(b) be qualified to perform the service and demonstrate capacity to perform required tasks;

(c) be able to communicate successfully with the participant;

(d) pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;

(e) complete training on critical incident, abuse, neglect, and exploitation reporting;

(f) complete participant specific training; the evaluation of training needs is determined by the participant or his/her legal representative; the participant is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the mi via participant's AAB; and

(g) meet any other service specific qualifications, as specified in these regulations.

(2) Vendors, including those providing professional services, shall:

(a) be qualified to provide the service;

(b) possess a valid business license, if applicable;

(c) if a professional provider, be required to follow the applicable licensing regulations set forth by the profession; refer to the appropriate New Mexico board of licensure for information regarding applicable licenses;

(d) if a consultant provider, meet all of the qualifications set forth in 8.314.6.11 NMAC;

(e) if a currently approved waiver provider, be in good standing with the appropriate state agency; and

(f) meet any other service specific qualifications, as specified in the mi via regulations.

(3) Relatives/legal representatives except LRIs (e.g., parents of minor children or spouses) may be hired and paid for provision of waiver services (except consultant/support guide, assisted living, and customized community supports services); payment is made to a participant's relative or legal representative for services provided when the relative/legal representative is qualified and approved to provide the service; the services must be identified in the approved SSP and AAB, and the participant or his/her legal representative is responsible for verifying that services have been rendered by completing, signing and submitting documentation, including the timesheet, to the FMA; relatives/legal representatives must provide services within the limits of the approved SSP and AAB and may not be paid in excess of 40 hours in a consecutive seven-day period; LRIs, legal representatives or relatives may not be both a paid employee for a participant and serve as his/her EOR.

(4) LRIs, e.g., the parent (biological, legal or adoptive) of a minor child (under age 18) or the guardian of a minor child, who must provide care to the child, or a spouse of a mi via participant, may be hired and paid for provision of waiver services (except consultant/support guide, assisted living, and customized community supports services) under extraordinary circumstances in order to assure the health and welfare of the participant, to avoid institutionalization and provided that the state is eligible to receive federal financial participation (FFP).

(a) Extraordinary circumstances include the inability of the LRI to find other qualified, suitable caregivers when the LRI

would otherwise be absent from the home and, thus, the caregiver must stay at home to ensure the participant's health and safety.

(b) LRIs may not be paid for any services that they would ordinarily perform in the household for individuals of the same age who do not have a disability or chronic illness.

(c) Services provided by LRIs must:

(i) meet the definition of a service or support and be specified in the participant's approved SSP and AAB;

(ii) be provided by a parent or spouse who meets the provider qualifications and training standards specified in the waiver for that service; and

(iii) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and be approved by the TPA.

(d) An LRI who is a service provider must comply with the following:

(i) a parent, parents in combination, or a spouse, may not provide more than 40 hours of services in a consecutive seven-day period; for parents, 40 hours is the total amount of service regardless of the number of children who receive services under the waiver;

(ii) planned work schedules must be identified in the approved SSP and AAB, and variations to the schedule must be reported to the participant's consultant and noted and supplied to the FMA when billing; and

(iii) timesheets and other required documentation must be maintained and submitted to the FMA for hours paid.

(e) Married individuals must be offered a choice of providers. If they choose a spouse as their service provider and it is approved in writing by ALTSD or DOH, it must be documented in the SSP.

(f) Children 16 years of age or older must be offered a choice of provider. If a child chooses his or her parent and it is approved in writing by ALTSD or DOH, it must be documented in the SSP.

(g) The FMA monitors, on a monthly basis, hours billed for services provided by the LRI and the total amounts billed for all goods and services during the month.

(h) Hiring of LRIs must be approved in writing by ALTSD for CoLTS (c) and BI populations, or DOH for the AIDS, DD and MF populations.

(5) Once enrolled, providers, vendors and contractors receive a packet of information from the mi via participant or FMA, including medicaid billing instructions, and other pertinent materials. Mi via participants are responsible for ensuring that providers, vendors and contractors have received these materials and for updating them as new materials are received from the state (ALTSD for CoLTS (c), and BI or DOH for AIDS, DD, and MF).

(a) No provider of any type may be paid in excess of 40 hours within the established work week for any one participant or EOR.

(b) No provider agency is permitted to perform both LOC assessments and provide any services for mi via participants.

(c) Mi via providers may market their services, but are prohibited from soliciting participants under any circumstances.

(6) Employer of record. The EOR is the individual responsible for directing the work of employees. Mi Via encourages the participant to be the EOR. It is also possible to designate someone else to act as the EOR.

(a) If a participant is the subject of a plenary or limited guardianship or conservator regarding financial matters, he/she may not be his or her own EOR.

(b) A person under the age of 18 years may not be an EOR.

(c) An EOR who lives outside New Mexico shall reside within 100 miles of the New Mexico state border. If the participant wants to have an EOR who resides beyond this radius, he/she must obtain written approval from the appropriate state program manager prior to the EOR performing any duties.

(d) A participant's provider may not also be his/her EOR.

(e) An EOR whose performance compromises the health, safety or welfare of the participant, may have his/her status as an EOR terminated.

(f) An EOR may not be paid for any services provided to the participant for whom they are the EOR, whether as an employee of the participant, a vendor, or an employee or contactor of an agency. An EOR makes important determinations about what is in the best interest of a participant, and should not have any conflict of interest. An EOR assists in the management of the participant's budget and should have no personal benefit connected to the services requested or approved on the budget.

C. **Service specific qualifications for consultant services providers:** Consultant providers shall ensure that all individuals providing consultant services meet the criteria specified in this section in addition to the general requirements.

(1) Consultant providers shall:

(a) possess a minimum of a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field, and have one year of supervised experience working with seniors or people living with disabilities; or

(b) have a minimum of six years of direct experience related to the delivery of social services to seniors or people living with disabilities, and be employed by an enrolled mi via consultant provider agency; and

(c) complete all required mi via orientation and training courses.

(2) Consultant providers may also use non-professional staff to carry out support guide functions. Support guides provide more intensive supports, as detailed in the service section of these rules. Support guides help the participant more effectively self-direct services when there is an identified need for this type of assistance. Consultant providers shall ensure that non-professional support staff:

(a) are supervised by a qualified consultant as specified in this regulation;

(b) have experience working with seniors or people living with disabilities;

(c) demonstrate the capacity to meet the participant's assessed needs related to the implementation of the SSP;

(d) possess knowledge of local resources, community events, formal and informal community organizations and networks;

(e) are able to accommodate a varied, flexible and on-call type of work schedule in order to meet the needs of participant; and

(f) complete training on self-direction and incident reporting.

D. **Service specific qualifications for personal plan facilitation providers:** A personal plan facilitator agency must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Personal plan facilitators must possess the following qualifications in addition to the general qualifications:

(1) have at least one year of experience working with persons with disabilities; and

(2) be trained and certified in the planning tool(s) used; and

(3) have at least one year experience in providing the personal plan facilitation service.

E. **Service specific qualification for living supports providers:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) **Qualifications of homemaker/direct support service providers:** Homemaker agencies must be certified by the HSD/MAD or its designee. Home health agencies must hold a home health agency license. Homemaker/home health agencies must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements.

(2) **Qualifications of home health aide service providers:** Home health agency/homemaker agencies must hold a current home health agency, rural health clinic, or federally qualified health center license. Home health aides must have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program pursuant to 7.28.2.30 NMAC. Home health aides must also be supervised by a registered nurse. Such supervision must occur at least once every 60 days in the participant's home, and shall be in accordance with the New Mexico Nurse Practice Act and be specific to the participant's SSP.

(3) **Qualifications of assisted living providers:** Assisted living providers must be licensed as an adult residential care facility by DOH pursuant to 7.8.2 NMAC, and meet all the requirements and regulations set forth by DOH as an adult residential care facility pursuant to 7.8.2 NMAC et seq.

(4) **Qualifications of customized in-home living supports providers:** The individual customized living provider must have at least one year of experience working with people with disabilities. Provider agencies must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Customized living agency staff must have one year of experience working with people with disabilities.

F. **Service specific qualifications for community membership support providers:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided. Community access provider agencies providing community direct support services must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements.

(1) **Qualifications of supported employment providers:**

(a) Job developers must have experience as a job developer for at least one year; have experience for at least one year developing and using job and task analyses; have experience for at least one year working with the division of vocational rehabilitation (DVR), a traditional DD waiver employment provider, an independent living center or other organization that provides employment supports or services for people with disabilities; and be trained on the purposes, functions and general practices of entities such as the department of workforce solutions navigators, one-stop career centers, business leadership network, chamber of commerce, job accommodation network, small business development centers, retired executives and New Mexico employment institute.

(b) Job coaches must have experience as a job coach for at least one year in the state of New Mexico; have experience for at least one year using job and task analyses; be trained on the Americans with Disabilities Act (ADA); and be trained on the purpose, function and general practices of the DVR office.

(2) **Qualifications of customized community supports providers:** Adult habilitation agency staff must have at least one year of experience working with individuals with disabilities. Adult day health provider agencies must be licensed by DOH as an adult day care facility pursuant to 7.13.2 NMAC. Adult day health agency staff must have at least one year of experience working with individuals with disabilities.

G. **Service specific qualifications for providers of health and wellness supports:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) **Qualifications of extended state plan skilled therapy providers for adults:** Physical and occupational therapists, speech/language pathologists, and physical therapy assistants must possess a therapy license in their respective field from the New Mexico regulation and licensing department (RLD). Certified occupational therapy assistants must possess an occupational therapy assistant certification from the New Mexico RLD. Speech clinical fellows must possess a clinical fellow license from the New Mexico RLD.

(2) **Qualifications of behavior support consultation providers:** Behavior consultant provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior consultant provider agencies shall comply with all applicable federal, state, and waiver regulations, policies and procedures regarding behavior consultation. Providers of behavior support consultation services must possess qualifications in at least one of the following areas: licensed psychiatrist, licensed clinical psychologist, licensed psychologist associate, (masters or Ph.D. level), licensed independent social worker (LISW), licensed master social worker (LMSW), licensed professional clinical counselor (LPCC), licensed professional counselor (LPC), licensed psychiatric nurse (MSN/RNCS), licensed marriage and family therapist (LMFT), or licensed practicing art therapist (LPAT). Providers of behavior support consultation must maintain a current New Mexico license with the appropriate professional field licensing body.

(3) **Qualifications of nutritional counseling providers:** Nutritional counseling providers must maintain a current registration as dietitians by the commission on dietetic registration of the American dietetic association.

(4) **Qualifications of private duty nursing providers for adults:** Direct nursing services are provided by individuals who are currently licensed as registered or practical nurses by the New Mexico state board of nursing.

(5) **Qualifications of specialized therapy providers:** Specialized therapy providers must possess a current New Mexico state license, as applicable, in at least one of the following areas:

(a) acupuncture and oriental medicine;

(b) biofeedback or a health care profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision;

(c) chiropractic medicine;

(d) cognitive rehabilitation therapy or a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision;

(e) hippotherapy or a health care profession whose scope of practice includes hippotherapy, and appropriate specialized training and experience;

(f) massage therapy;

(g) naprapathic medicine;

(h) play therapy or a mental health profession whose scope of practice includes play therapy, a master's degree or higher mental health degree, and specialized play therapy training and clinical experience and supervision; or

(i) Native American healers are individuals who are recognized as traditional healers within their communities.

H. **Service specific qualifications for other supports providers:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) **Qualifications of transportation providers:** Individual transportation providers must possess a valid New Mexico driver's license with the appropriate classification, be free of physical or mental impairment that would adversely affect driving performance, have no driving while intoxicated (DWI) convictions or chargeable (at fault) accidents within the previous two years, have current CPR/first aid certification; and be trained on DOH/division of health improvement (DHI) critical incident reporting procedures and have a current insurance policy and vehicle registration. Transportation vendors must hold a current business license and tax identification number. Each agency will ensure drivers meet the following qualifications:

(a) possess a valid, appropriate New Mexico driver's license;

(b) be free of physical or mental impairment that would adversely affect driving performance;

(c) have no DWI convictions or chargeable (at fault) accidents within the previous two years;

(d) have current CPR/first aid certification;

(e) be trained on DOH/DHI critical incident reporting procedures;

(f) have a current insurance policy and vehicle registration; and

(g) each agency will ensure vehicles have a current basic first aid kit in the vehicle.

(2) **Qualifications of emergency response providers:** Emergency response providers must comply with all laws, rules and regulations of the New Mexico state corporation commission for telecommunications and security systems.

(3) **Qualifications of respite providers:** Respite services may be provided by eligible individual respite providers; licensed registered (RN) or practical nurses (LPN); or respite provider agencies. Individual RN/LPN providers must be licensed by the New Mexico state board of nursing as an RN or LPN. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements.

(4) **Qualifications of related goods vendors:** Related goods vendors must hold a current business license for the locale they are in and a tax ID for the state and federal government.

(5) **Qualifications of environmental modifications providers:** Environmental modification providers must possess an appropriate plumbing, electrician, contractor or other appropriate license.

[8.314.6.11 NMAC - Rp, 8.314.6.11 NMAC, 4-1-11]

8.314.6.12 RECORDKEEPING AND DOCUMENTATION RESPONSIBILITIES: Service providers and vendors who furnish goods and services to mi via participants are reimbursed by the FMA and must comply with all mi via regulations. The FMA, consultants and service providers must maintain records, which are sufficient to fully disclose the extent and nature of the goods and services provided to participants, pursuant to 8.302.1.17 NMAC, *record keeping and documentation requirements*, and comply with random and targeted audits conducted by HSD/MAD, ALTSD, and DOH or their audit agents. HSD/MAD or its designee will seek recoupment of funds from service providers when audits show inappropriate billing for services. Mi via vendors who furnish goods and services to mi via participants and bill the FMA must comply with all medicaid participation requirements, including but not limited to 8.302.1 NMAC, *General Provider Policies*.

[8.314.6.12 NMAC - Rp, 8.314.6.12 NMAC, 4-1-11]

8.314.6.13 ELIGIBILITY REQUIREMENTS FOR PARTICIPANT ENROLLMENT IN MI VIA: Enrollment in mi via is contingent upon the applicant meeting the eligibility requirements as described in the mi via regulations, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated participants. When sufficient funding as well as waiver positions are available, the appropriate state administering agency will offer the opportunity to individuals to apply for mi via. Once an allocation has been offered to the applicant he/she must meet certain medical and financial criteria in order to qualify for enrollment. Applicants must meet the following eligibility criteria: financial eligibility criteria determined in accordance with 8.290.500 NMAC, and the participant must meet the LOC required for admittance to an NF or an ICF/MR and additional specific criteria as specified in the categories below.

A. **Developmental disability:** Individuals who have a severe chronic disability, other than mental illness, that:

(1) is attributable to a mental or physical impairment, including the result of trauma to the brain, or a combination of mental and physical impairments;

(2) is manifested before the person reaches the age of 22 years;

(3) is expected to continue indefinitely;

(4) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency;

(5) reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other supports and services that are of life-long or extended duration and are individually planned and coordinated;

(6) the individual must have a developmental disability and mental retardation or a specific related condition; related conditions are limited to cerebral palsy, autism (including asperger syndrome), seizure disorder, chromosomal disorders (e.g. down), syndrome disorders, inborn errors of metabolism, and developmental disorders of brain formation; and

(7) the individual must require an ICF/MR LOC.

B. **Medically fragile:** Individuals who have been diagnosed with a medically fragile condition before reaching age 22, and who:

(1) have a developmental disability or developmental delay, or who are at risk for developmental delay; and

(2) have a chronic physical condition which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:

(a) have a life-threatening condition, characterized by reasonably frequent periods of acute exacerbation, which requires frequent medical supervision or physician consultation, and which, in the absence of such supervision or consultation, would require hospitalization; or have frequent, time-consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen; and

(b) require ICF/MR LOC.

C. **Disabled and elderly:** Individuals who are elderly (age 65 or older), blind or disabled, as determined by the disability determination unit utilizing social security disability guidelines, who require NF LOC and either reside in the community, are institutionalized, or are at risk of institutionalization.

D. **AIDS:** Individuals who have been diagnosed as having AIDS or AIDS-related condition (ARC) and who require NF LOC.

E. **Brain-injury (BI):** Individuals (through age 64) with an injury to the brain of traumatic or acquired origin resulting in total or partial functional disability or psychosocial impairment or both. Additional criteria include:

(1) the term applies to open and closed head injuries caused by an insult to the brain from an outside physical force, anoxia, electrical shock, shaken baby syndrome, toxic and chemical substances, near-drowning, infections, tumors, or vascular lesions;

(2) BI may result in either temporary or permanent, partial or total impairments in one or more areas including, but not limited to: cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem solving, sensory perceptual and motor abilities, psychosocial behavior, physical functions, information processing and speech;

(3) the term "***brain injury"*** does not apply to brain injuries that are

congenital, degenerative, induced by birth trauma or neurological disorders related to the aging process, or chemically caused brain injuries that are a result of habitual substance abuse; the BI participant must have a documented BI diagnosis contained in the ICD-9-CM document (see Attachment I to these regulations); and

(4) the individual must require NF LOC.

F. After initial eligibility has been established, on-going eligibility must be re-determined on an annual basis.

[8.314.5.13 NMAC -Rp, 8.314.6.13 NMAC, 4-1-11]

8.314.6.14 PARTICIPANT RESPONSIBILITIES: Mi via participants have certain responsibilities to participate in the waiver. Failure to comply with these responsibilities or other program rules and regulations can result in termination from the program. The participant and EOR have the following responsibilities.

A. To maintain eligibility a participant must complete required documentation demonstrating medical and financial eligibility both upon application and annually at recertification, meet in person with the TPA for a comprehensive LOC assessment in the applicant/participant's home, an agreed upon location or an inpatient setting, and seek assistance with the application and the recertification process as needed from a mi via consultant.

B. To participate in mi via a participant must:

(1) comply with the rules and regulations that govern the program;

(2) collaborate with the consultant to determine support needs related to the activities of self-direction;

(3) collaborate with the consultant to develop an SSP using the IBA in accordance with mi via program regulations;

(4) use state funds appropriately by only requesting and purchasing goods and services covered by the mi via program in accordance with program regulations and which are identified on the approved SSP;

(5) comply with the approved SSP and not exceed the AAB;

(a) if a participant does not adequately allocate the resources contained in the AAB resulting in a premature depletion of the AAB amount during an SSP year due to mismanagement or failure to properly track expenditures, the failure to properly allocate does not substantiate a claim for a budget increase (i.e., if all of the AAB is expended within the first three months of the SSP year, it is not justification for an increase in the budget for the SSP year);

(b) revisions to the AAB may occur within the SSP year, and the participant is responsible for assuring that all expenditures are in compliance with the most current AAB in effect; the SSP must be amended first to reflect a change in the participant's needs or circumstances before any revisions to the AAB can be requested; other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review during the first 90 days of the participant's budget year, or within the last 60 days of the budget year;

(c) no mi via program funds can be used to purchase goods or services prior to TPA approval of the SSP and annual budget request;

(d) any funds not utilized within the SSP and AAB year cannot be carried over into the following year;

(6) access consultant services based upon identified need(s) in order to carry out the approved SSP;

(7) collaborate with the consultant to appropriately document service delivery and maintain those documents for evidence of services received;

(8) report concerns or problems with any part of mi via to the consultant;

(9) work with the TPA agent by attending scheduled meetings, in the participant's home if necessary and providing documentation as requested;

(10) respond to requests for additional documentation and information from the consultant provider, FMA, and the TPA within the required deadlines;

(11) report to the local income support division office within 10 days any change in circumstances, including a change in address, which might affect eligibility for the program. Changes in address or other contact information must also be reported to the consultant provider and the FMA within 10 days;

(12) report to the TPA and consultant provider if hospitalized for more than three nights so that an appropriate LOC can be obtained; and

(13) keep track of all budget expenditures and assure that all expenditures are within the AAB; and

(14) meet monthly and quarterly with the consultant.

C. Additional responsibilities of the participant or EOR:

(1) Submit all required documents to the FMA to meet employer-related responsibilities. This includes, but is not limited to documents for payment to employees and vendors and payment of taxes and other financial obligations within required timelines.

(2) Report any incidents of abuse, neglect or exploitation to the appropriate state entity.

(3) Arrange for the delivery of services, supports and goods.

(4) Hire, manage, and terminate employees.

(5) Maintain records and documentation in accordance with 8.302.1.17 NMAC, related to personnel, payroll and service delivery.

D. **Voluntary termination:** Current waiver participants are given a choice of receiving services through an existing waiver or mi via. Mi via participants, who transition from the current traditional waivers (CoLTS(c), DD, MF, or AIDS) and decide to discontinue self-directing their services, may return to the traditional waiver in accordance with the mi via rules and service standards. Mi via participants who are eligible under the BI category of eligibility and choose to discontinue self-direction may be transitioned to CoLTS (c) services.

E. **Involuntary termination:** A mi via participant may be terminated involuntarily and offered services through another waiver or the medicaid state plan under the following circumstances.

(1) The participant refuses to follow mi via rules and regulations after receiving focused technical assistance on multiple occasions, support from the program staff, consultant, or FMA, which is supported by documentation of the efforts to assist the participant.

(2) The participant is in immediate risk to his/her health or safety by continued self-direction of services, e.g., the participant is in imminent risk of death or serious bodily injury related to participation in the waiver. Examples include but are not limited to the following.

(a) The participant refuses to include and maintain services in his/her SSP and AAB that would address health and safety issues identified in his/her medical assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, consultant, or FMA.

(b) The participant is experiencing significant health or safety needs, and, after having been referred to the state contractor team for level of risk determination and assistance, refuses to incorporate the team's recommendations into his/her SSP and AAB.

(c) The participant exhibits behaviors which endanger him/herself or others.

(3) The participant misuses mi via funds following repeated and focused technical assistance and support from the consultant or FMA, which is supported by documentation.

(4) The participant commits medicaid fraud.

(5) Participant who is involuntarily terminated from mi via will be offered a non self-directed waiver alternative. If transfer to another waiver is authorized by the state and accepted by the participant, he/she will continue to receive the services and supports from mi via until the day before the

new waiver services start. This will ensure that no break in service occurs. The mi via consultant and the service coordinator in the new waiver will work closely together with the participant to ensure that the participant's health and safety is maintained. Fair hearing notice and rights apply to the participant.
[8.314.6.14 NMAC -Rp, 8.314.6.14 NMAC, 4-1-11]

8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA: The services covered by mi via are intended to provide a community-based alternative to institutional care that allows greater choice, direction and control over services and supports in a self-directed environment. Mi via services must specifically address a therapeutic, rehabilitative, habilitative, health or safety need that results from the participant's qualifying condition. The mi via program is the payor of last resort. The coverage of mi via services must be in accordance with the mi via program regulations.

A. **General requirements regarding mi via covered services:** For a service to be considered a covered service under the mi via program, the following criteria must be met. Services, supports and goods must:

(1) directly address the participant's qualifying condition or disability;

(2) meet the participant's clinical, functional, medical or habilitative needs;

(3) be designed and delivered to advance the desired outcomes in the participant's service and support plan; and

(4) support the participant to remain in the community and reduce the risk of institutionalization.

B. **Consultant pre-eligibility/enrollment services:** Consultant pre-eligibility/enrollment services are intended to provide information, support, guidance, and assistance to individuals during the medicaid financial and medical eligibility process. The level of support provided is based upon the unique needs of the individual. When an opportunity to be considered for mi via waiver services is offered to an individual, he/she must complete a primary freedom of choice form. The purpose of this form is for the individual to select a consultant provider. The chosen consultant provider provides pre-eligibility/enrollment services as well as on-going consultant services. Once the individual is determined to be eligible for mi via waiver services, the consultant service provider will continue to provide consultant services to the newly enrolled participant as set forth in the consultant service standards.

C. **Consultant services:** Consultant services are required for all mi via participants to educate, guide, and assist the participant to make informed planning decisions about services and supports. The consultant helps the participant develop the SSP based on his/her assessed needs. The consultant assists the participant with implementation and quality assurance related to the SSP and AAB. Consultant services help the participant identify supports, services and goods that meet his/her needs, meet the mi via requirements and are covered mi via services. Consultant services provide support to participants to maximize their ability to self-direct in mi via.

(1) **Contact requirements:** Consultant providers shall make contact with the participant in person or by telephone at least monthly for a routine follow-up. Consultant providers shall meet in person with the participant at least quarterly for the following purposes:

(a) review and document progress on implementation of the SSP;

(b) document usage and effectiveness of the 24-hour emergency backup plan;

(c) review SSP/budget spending patterns (over and under-utilization);

(d) assess quality of services, supports and functionality of goods in accordance with the quality assurance section of the SSP and any applicable mi via regulations and service standards;

(e) document the participant's access to related goods identified in the SSP;

(f) review any incidents or events that have impacted the participant's health, welfare or ability to fully access and utilize support as identified in the SSP; and

(g) other concerns or challenges raised by the participant, legal representative, or authorized representative.

(2) **Change of consultants:** Consultants are responsible for assisting participants to transition to another consultant provider when requested. Transition from one consultant provider to another can only occur at the first of the month.

(3) **Critical incident management responsibilities and reporting requirements:** The consultant provider shall provide training to participants regarding recognizing and reporting critical incidents. Critical incidents include abuse, neglect, exploitation, emergency services, law enforcement involvement, environmental hazards and participant deaths. This participant training shall also include reporting procedures for participants, employees, participant representatives or other designated individuals. The consultant provider shall report incidents of abuse, neglect and exploitation as directed by the state. The consultant provider shall maintain a critical incident management system to identify, report, and address critical incidents. The consultant provider is responsible for follow-up and assisting the individual to help ensure health and safety when a critical incident has occurred. Critical incident reporting requirements:

(a) For mi via participants who have been designated with an ICF/MR level of care, critical incidents should be directed in the following manner.

(i) The DOH/DHI/incident management bureau (IMB) receives, triages, and investigates all reports of alleged abuse, neglect, exploitation, and other incidents for mi via services provided by community-based waiver service agencies, to include expected and unexpected deaths. The reporting of incidents is mandated pursuant to 7.1.13 NMAC. Any suspected abuse, neglect, or exploitation must be reported to the children, youth and families department (CYFD)/child protective services (CPS) for individuals under the age of 18 or to the ALTSD/adult protective services (APS) for individuals age 18 or older by reporting or faxing an incident report (IR). Additionally, the IR form must be faxed to DOH/DHI within 24 hours of knowledge of an incident or the following business day when an event occurs on a weekend or holiday. Anyone may report an incident; however, the person with the most direct knowledge of the incident is the individual who is required to report the incident.

(ii) When an incident is reported late, and the mi via service is provided by a community-based waiver service agency, a letter is sent to the provider stating that an incident report was received beyond the required 24-hour timeline for reporting. The letter further reiterates the requirement to report incidents within 24 hours. The consequences of non-compliance may result in sanctions, as set forth in 7.1.13.12 NMAC.

(iii) With respect to waiver services provided by any employee, contractor or vendor other than a community-based waiver service agency, any suspected abuse, neglect, or exploitation must be reported to the CYFD/CPS for individuals under the age of 18 or to the ALTSD/APS for individuals age 18 or older by reporting or faxing an incident report. See NMSA 1978, Sections 27-7-14 through 27-7-31 (Adult Protective Services Act) and in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).

(b) For individuals in mi via that have been designated with an NF LOC, critical incidents should be directed to:

(i) ALTSD/APS for individuals age 18 or older or CYFD/CPS for individual under the age of 18 for critical incidents involving abuse, neglect or exploitation; and

(ii) ALTSD, elderly and disability services division (EDSD) as well as the managed care organization, if

applicable. The consultant provider shall fax all critical incidents in the standardized format provided by the state.

D. **Personal plan facilitation:** Personal plan facilitation supports planning activities that may be used by the participant to develop his/her SSP as well as identify other sources of support outside the SSP process. This service is available to participants one time per budget year.

(1) In the scope of personal planning facilitation, the personal plan facilitator will:

(a) meet with the participant and his/her family (or legal representative, as appropriate) prior to the personal planning session to discuss the process, to determine who the participant wishes to invite, and determine the most convenient date, time and location; this meeting preparation shall include an explanation of the techniques the facilitator is proposing to use or options if the facilitator is trained in multiple techniques; the preparation shall also include a discussion of the role the participant prefers to play at the planning session, which may include co-facilitation of all or part of the session;

(b) arrange for participation of invitees and location;

(c) conduct the personal planning session;

(d) document the results of the personal planning session and provide a copy to the participant, the consultant and any other parties the participant would like to receive a copy.

(2) Elements of this report shall include:

(a) recommended services to be included in the SSP;

(b) services from sources other than medicaid to aid the participant;

(c) long-term goals the participant wishes to pursue;

(d) potential resources, especially natural supports within the participant's community that can help the participant to pursue his or her desired outcomes(s)/goal(s); and

(e) a list of any follow-up actions to take, including time lines.

(3) Provide session attendees, including the participant, with an opportunity to provide feedback regarding the effectiveness of the session.

E. **Living supports:**

(1) **Homemaker/direct support services:** Homemaker/direct support services are provided on an episodic or continuing basis to assist the participant with activities of daily living, performance of general household tasks, and enable the participant to accomplish tasks he/she would normally do for him/herself if he/she did not have a disability. Homemaker/direct support services are provided in the participant's home and in the community, depending on the participant's needs. The participant identifies the homemaker/direct support worker's training needs, and, if the participant is unable to do the training him/herself, the participant arranges for the needed training. Services are not intended to replace supports available from a primary caregiver.

(a) Two or more participants living in the same residence, who are receiving services and supports from mi via will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved based on common needs and not individual needs, unless the TPA has assessed that there is an individual need for the services.

(b) Personal care services are covered under the medicaid state plan as expanded EPSDT benefits for waiver participants under age 21.

(2) **Home health aide services:** Home health aide services provide total care or assist an adult participant in all activities of daily living. Home health aide services assist the participant in a manner that will promote an improved quality of life and a safe environment for the participant. Home health aide services can be provided outside the participant's home. State plan home health aide services are intermittent and provided primarily on a short-term basis. Mi via home health aide services are hourly services for participants who need this service on a more long-term basis. Home health aide services are not duplicative of homemaker services. Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks.

(3) **Assisted living:** A residential service that includes personal care and supportive services (homemaker, chore, attendant services, meal preparation); medication oversight (to the extent permitted under state law); and 24-hour, on-site response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety, and security.

(a) Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board.

(b) Nursing and skilled therapy services are incidental, rather than integral, to the provision of assisted living services.

(c) Services (other than those included in the bundle of "assisted living" services) provided by third parties must be coordinated with the assisted living provider.

(d) Participants who access this service cannot utilize mi via homemaker/direct support, environmental modifications, emergency response, customized community supports and customized in-home living supports services because they are provided by assisted living services.

(4) **Customized in-home living supports:** Customized in-home living supports are related to the participant's qualifying condition or disability and enable him/her to live in his /her apartment or house. This is for homes/apartments owned or leased by the participant. This is not available for a provider's home.

(a) These services and supports are provided in the participant's home and are individually designed to instruct or enhance home living skills as well as address health and safety.

(b) Customized in-home living supports include assistance with activities of daily living and assistance with the acquisition, restoration, or retention of independent living skills. This service is provided on a regular basis at least four or more hours per day one or more days per week as specified in the service plan.

(c) Participants receiving customized in-home living supports may not use homemaker/direct support or home health aide services because they are provided by customized in-home living supports.

F. **Community membership supports:**

(1) **Community direct support:** Community direct support providers deliver support to the participant to identify, develop and maintain community connections and access social, educational, recreational and leisure options.

(a) The community direct support provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the participant to access the community.

(b) The community direct support provider may instruct and model social behavior necessary for the participant to interact with community members or in groups, provide assistance in ancillary tasks related to community membership, provide attendant care and help the participant schedule, organize and meet expectations related to chosen community activities.

(c) Community direct support services include:

(i) provide assistance to the participant outside of his/her residence and segregated facilities;

(ii) promote the development of social relationships and build connections within local communities;

(iii) support the participant in having frequent opportunities to expand roles in the community to increase and enhance natural supports, networks, friendships and build a sense of belonging; and

(iv) assist in the development of skills and behaviors that strengthen the participant's connection with his or her community.

(d) The skills to assist someone in a community setting may be different than those for assisting a person at home. The provider will:

(i) demonstrate knowledge of the local community and resources within that community that are identified by the participant on the SSP; and

(ii) be aware of the participant's barriers to communicating and maintaining health and safety while in the community setting.

(2) **Employment supports:** Employment supports include job development, support to find a job, and job coaching after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that a participant may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational or vocational assessments and profiles; education of the participant and co-workers on rights and responsibilities; and benefits counseling.

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

(i) job identification and development activities;

(ii) employer negotiations;

(iii) job restructuring;

(iv) job sampling; and

(v) job placement.

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

(c) Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA.

(d) FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

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

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

(iii) payments for training that is not directly related to an individual's supported employment program;

(iv) FFP cannot be claimed to defray expenses associated with starting up or operating a business.

(3) **Customized community supports:** Customized community supports can include participation in congregate community 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 adult day habilitation, adult day health and other 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 participant's SSP.

G. **Health and wellness:**

(1) **Extended state plan skilled therapy for adults:** Extended state plan skilled therapy for adults includes physical therapy, occupational therapy or speech language therapy. Services are provided when state plan skilled therapy services are exhausted. Adults on mi via access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to adults in mi via focus on improving functional independence, health maintenance, community integration, socialization, and exercise, or enhance support and normalization of family relationships.

(a) **Physical therapy:** Diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy activities do the following:

(i) increase, maintain or reduce the loss of functional skills;

(ii) treat a specific condition clinically related to a participant's disability;

(iii) support the participant's health and safety needs; or

(v) identify, implement, and train on therapeutic strategies to support the participant and his/her family or support staff consistent with the participant's SSP desired outcomes and goals.

(b) **Occupational therapy:** Diagnosis, assessment, and management of functional limitations intended to assist adults to regain, maintain, develop, and build skills that are important for independence, functioning, and health. Occupational therapy services typically include:

(i) customized treatment programs to improve the participant's ability to perform daily activities;

(ii) comprehensive home and job site evaluations with adaptation recommendations;

(iii) skills assessments and treatment;

(iv) assistive technology recommendations and usage training;

(v) guidance to family members and caregivers;

(vi) increasing or maintaining functional skills or reducing the loss of functional skills;

(vii) treating specific conditions clinically related to a participant's developmental disability;

(viii) support for the participant's health and safety needs, and

(ix) identifying, implementing, and training therapeutic strategies to support the participant and his/her family or support staff consistent with the participant's SSP desired outcomes and goals.

(c) **Speech and language pathology:** Diagnosis, counseling and instruction related to the development and disorders of communication including speech fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal, and sensor motor competencies. Speech language pathology is also used when a participant requires the use of an augmentative communication device. Based upon therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group. Services are intended to:

(i) improve or maintain the participant's capacity for successful communication or to lessen the effects of the participant's loss of communication skills; or

(ii) improve or maintain the participant's ability to eat foods, drink liquids, and manage oral secretions with minimal risk of aspiration or other potential injuries or illness related to swallowing disorders;

(iii) identify, implement and train therapeutic strategies to support the participant and his/her family or support staff consistent with the participant's SSP desired outcomes and goals.

(d) **Behavior support consultation:** Behavior support consultation services consist of functional support assessments, treatment plan development, and training and support coordination for a participant related to behaviors that compromise a participant's quality of life. Based on the participant's SSP, services are

delivered in an integrated, natural setting, or in a clinical setting. Behavior support consultation:

(i) informs and guides the participant's service and support employees/vendors toward understanding the contributing factors to the participant's behavior;

(ii) identifies support strategies to 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(s);

(iii) supports effective implementation based on a functional assessment and SSP;

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

(v) monitors and adapts support strategies based on the response of the participant and his/her service and support providers.

(e) **Nutritional counseling:** Nutritional counseling services include assessment of the participant's nutritional needs, development or revision of the participant's nutritional plan, counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.

(f) **Private duty nursing for adults:** Private duty nursing for adults includes activities, procedures, and treatment for a participant's physical condition, physical illness or chronic disability. Services include medication management, administration and teaching, aspiration precautions, feeding tube management, gastrostomy and jejunostomy, skin care, weight management, urinary catheter management, bowel and bladder care, wound care, health education, health screening, infection control, environmental management for safety, nutrition management, oxygen management, seizure management and precautions, anxiety reduction, staff supervision, behavior and self-care assistance.

(2) **Specialized therapies:** Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. Experimental or investigational procedures, technologies or therapies and those services covered as a medicaid state plan benefit are excluded. Services in this category include the following therapies:

(a) **Acupuncture:** 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 mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. See acupuncture and oriental medicine practitioners 16.2.1 NMAC.

(b) **Biofeedback:** Biofeedback uses visual, auditory or other monitors to feed back to patients physiological information of which they are normally unaware. This technique enables an individual 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 to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

(c) **Chiropractic:** Chiropractic care 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, 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. See chiropractitioners 16.4.1 NMAC.

(d) **Cognitive rehabilitation therapy:** Cognitive rehabilitation therapy services 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 activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive problems.

(e) **Hippotherapy:** 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 individuals with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the individual use cognitive functioning, especially for sequencing and memory. Individuals with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production.

(f) **Massage therapy:** Massage therapy 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, an individual's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities. See massage therapists 16.7.1 NMAC.

(g) **Naprapathy:** 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. See naprapathic practitioners 16.6.1 NMAC.

(h) **Native American healers:** Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support participants in their communities by addressing their physical, emotional and spiritual health. Treatments may include prayer, dance, ceremony, song, plant medicines, foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel or other sacred objects.

(i) **Play therapy:** Play therapy is a variety of play and creative arts techniques ("the play therapy tool-kit") utilized to alleviate chronic, mild and moderate

psychological and emotional conditions in children that are causing behavioral problems or are preventing children from realizing their potential. The play therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the child's wishes.

H. **Other supports:**

(1) **Transportation:** Transportation services are offered to enable participants to gain access to services, activities, and resources, as specified by the SSP. Transportation services under the waiver are offered in accordance with the participant's SSP. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the medicaid state plan are to transport participants to medically necessary physical and behavioral health services. Payment for mi via transportation services is made to the participant's individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the participant. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge shall be identified in the SSP and utilized.

(2) **Emergency response services:** Emergency response services provide an electronic device that enables a participant to secure help in an emergency at home and avoid institutionalization. The participant may also wear a portable help button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center when a help button is activated. The response center is staffed by trained professionals. Emergency response services include:

(a) testing and maintaining equipment;

(b) training participants, caregivers and first responders on use of the equipment;

(c) 24-hour monitoring for alarms;

(d) checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.;

(e) reporting emergencies and changes in the participant's condition that may affect service delivery; and

(f) ongoing emergency response service is covered, but initial set up and installation is not.

(3) **Respite:** Respite is a family support service, the primary purpose of which is to give the primary caregiver time away from his/her duties. Respite services include assisting the participant with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the participant to enhance self-help skills, leisure time skills and community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the participant to make his/her own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the participant's home, the provider's home, in a community setting of the family's choice (e.g., community center, swimming pool and park) or at a center in which other individuals are provided care. FFP is not claimed for the cost of room and board as part of respite services.

(4) **Related goods:** Related goods are equipment, supplies or fees and memberships, not otherwise provided through mi via, the medicaid state plan, or medicare.

(a) Related goods must address a need identified in the participant's SSP and meet the following requirements:

(i) be responsive to the participant's qualifying condition or disability; and

(ii) meet the participant's clinical, functional, medical or habilitative needs; and

(iii) supports the participant to remain in the community and reduces the risk for institutionalization; and

(iv) promote personal safety and health; and afford the participant an accommodation for greater independence; and

(v) decrease the need for other medicaid services; and

(vi) accommodate the participant in managing his/her household; or

(vii) facilitate activities of daily living.

(b) Related goods must be documented in the SSP, comply with Paragraph (3) of Subsection D of 8.314.6.17 NMAC, and be approved by the TPA. The cost and type of related good is subject to approval by the TPA. Participants are not guaranteed the exact type and model of related good that is requested. The consultant, TPA or the state can work with the participant to find other (including less costly) alternatives.

(c) The related goods must not be available through another source and the participant must not have the personal funds needed to purchase the goods.

(d) These items are purchased from the participant's AAB.

(e) Experimental or prohibited treatments and goods are excluded.

(5) **Environmental modifications:** Environmental modification services include the purchase and installation of equipment or making physical adaptations to a participant's residence that are necessary to ensure the health, safety, and welfare of the participant or enhance the participant's level of independence.

(a) Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing; turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems or signaling devices.

(b) All services shall be provided in accordance with applicable federal, state, and local building codes.

(c) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant, such as fences, storage sheds or other outbuildings. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

(d) The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation; provide or secure licensed insured and bonded contractor(s) or approved vendor(s) to provide construction/ remodeling services; provide administrative and technical oversight of construction projects; provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the participant's residence; and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

(e) Environmental modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects.

(f) Environmental modification services are limited to $7,000 every five years. Environmental modifications must be approved by the TPA.

(g) Environmental modifications are paid from a funding source separate from the AAB.

[8.314.6.15 NMAC - Rp, 8.314.6.15 NMAC, 4-1-11]

8.314.6.16 NON-COVERED SERVICES: Non-covered services include,

but are not limited to the following:

A. services covered by the medicaid state plan (including EPSDT), medicaid school-based services, medicare and other third-parties;

B. any service or good, the provision of which would violate federal or state statutes, regulations or guidance;

C. formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by DVR;

D. room and board, meaning shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing, 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. any goods or services that are to be used primarily for recreational or diversional purposes;

H. personal goods or items not related to the disability;

I. service animals and the costs of maintaining service animals, with the exception of training and certification;

J. gas cards and gift cards;

K. purchase of insurance, such as car, health, life, burial, renters, home-owners, service warrantees or other such policies;

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

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

N. firearms, ammunition or other weapons;

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

P. vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses;

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

R. purchase of food, maintenance, routine veterinary visits, medication, grooming and boarding for any therapeutic service or assistance animal;

S. purchase of any pet animal, food, maintenance, routine veterinary visits, medication, grooming and boarding costs associated with maintaining any pet;

T. 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 participant's qualifying condition or disability;

U. 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 participant's qualifying condition or disability; requests must include documentation that the adapted vehicle is the participant's primary means of transportation;

V. clothing and accessories, except specialized clothing based on the participant's disability or condition;

W. training expenses for paid employees;

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

Y. consumer electronics such as computers, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.15 NMAC; and

Z. if a participant requests a good or service, the consultant TPA and the state can work with the participant to find other (including less costly) alternatives.

[8.314.6.16 NMAC - Rp, 8.314.6 NMAC, 4-1-11]

8.314.6.17 SERVICE AND SUPPORT PLAN (SSP) AND AUTHORIZED ANNUAL BUDGET(AAB): An SSP and an annual budget request are developed at least annually by the mi via participant in collaboration with the participant's consultant and others that the participant invites to be part of the process. The consultant serves in a supporting role to the mi via_participant, assisting the participant to understand mi via, and with developing and implementing the SSP and the AAB. The SSP and annual budget request are developed and implemented in accordance with the mi via program rules and service standards and submitted to the TPA for final approval. Upon final approval the annual budget request becomes an AAB.

A. **SSP development process:** For development of the participant-centered service plan, the planning meetings are scheduled at times and locations convenient to the participant. The state obtains information about participant strengths, capacities, preferences, desired outcomes and risk factors through the LOC assessment and the planning process that is undertaken between the consultant and participant to develop the participant's SSP. If the participant chooses to purchase personal plan facilitation services, that assessment information would also be used in developing the SSP.

(1) **Assessments:**

(a) Assessment activities that occur prior to the SSP meeting assist in the development of an accurate and functional plan. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social and employment; LOC assessments are conducted in person and take place in the applicant/participant's home, an agreed upon location or an inpatient setting.

(b) Assessments occur on an annual basis or during significant changes in circumstance or at the time of the LOC determination. After the assessments are completed, the results are made available to the participant and his/her consultant for use in planning.

(c) The participant and the consultant will assure that the SSP addresses the information and concerns, if any, identified through the assessment process.

(d) Participant/employer self assessments are completed prior to SSP meetings (participant/employer self assessments may be revised during the year to address any life changes). The SSP must address areas of need, as recognized in the participant/employer self-assessment.

(2) **Pre-planning:**

(a) The consultant contacts the participant upon his/her choosing mi via to provide information regarding mi via, including the range and scope of choices and options, as well as the rights, risks, and responsibilities associated with self-direction.

(b) The consultant discusses areas of need to address on the participant's SSP. The consultant provides support during the annual recertification process to assist with completing medical and financial eligibility in a timely manner.

(c) Personal plan facilitators are optional supports. To assist in pre-planning, the participant is also able to access an approved provider to develop a personal plan.

(3) **SSP components:** The SSP contains:

(a) the waiver services that are furnished to the mi via participant, the projected amount, frequency and duration, and the type of provider who furnishes each service;

(i) the SSP must describe in detail how the services or goods relate to the participant's qualifying condition or disability;

(ii) the SSP must describe how the services and goods support the participant to remain in the community and reduce his/her risk of institutionalization; and

(iii) the SSP must specify the hours of services to be provided and payment arrangements;

(b) other services needed by the mi via participant regardless of funding source, including state plan services;

(c) informal supports that complement waiver services in meeting the needs of the participant;

(d) methods for coordination with state plan services and other public programs;

(e) methods for addressing the participant's health care needs when relevant;

(f) quality assurance criteria to be used to determine if the services and goods meet the participant's needs as related to his/her qualifying condition or disability;

(g) information, resources or training needed by the mi via participant and service providers;

(h) methods to address the participant's health and safety, such as 24-hour emergency and back-up services; and

(i) the IBA.

(4) **Service and support plan meeting:**

(a) The participant receives an LOC assessment and local resource manual prior to the SSP meeting.

(b) The participant may begin planning and drafting the SSP utilizing those tools prior to the SSP meeting.

(c) During the SSP meeting, the consultant assists the participant to ensure that the SSP addresses the participant's goals, health, safety and risks. The participant and the consultant will assure that the SSP addresses the information and concerns identified through the assessment process. The SSP must address the participant's health and safety needs before addressing other issues. The consultant ensures that:

(i) the planning process addresses the participant's needs and goals in the following areas: health and wellness and accommodations or supports needed at home and in the community;

(ii) services selected address the participant's needs as identified during the assessment process; needs not addressed in the SSP will be addressed outside the mi via program;

(iii) the outcome of the assessment process for assuring health and safety is considered in the plan;

(iv) services do not duplicate or supplant those available to the participant through the medicaid state plan or other programs;

(v) services are not duplicated in more than one service code;

(vi) job descriptions are complete for each provider and employee in the plan; job descriptions will include frequency, intensity and expected outcomes for the service;

(vii) the quality assurance section of the SSP is complete and specifies the roles of the participant, consultant and any others listed in this section;

(viii) the responsibilities are assigned for implementing the plan;

(ix) the back-up plans are complete; and

(x) the SSP is submitted to the TPA after the SSP meeting, in compliance with mi via waiver rules.

B. **Individual budgetary allotment (IBA):** Each mi via participant's annual IBA is determined by the state as follows.

(1) Budgetary allotments are based on calculations developed by the state for each mi via population group, including AIDS, former Disabled & Elderly (D&E) now CoLTS (c), DD or MF waiver, and BI category of eligibility, utilizing historical traditional waiver care plan authorized budgets within the population, minus the case management costs, and minus a 10 percent discount; the budget metholodogy is attached to this section of the NMAC as Attachment II.

(2) The determination of each mi via participant's sub-group is based on a comprehensive assessment. The participant then receives the IBA available to that sub-group, according to the participant's age, the IBA for each sub-group is attached to this section as Attachment III.

(3) A mi via participant has the authority to expend the IBA through an AAB that is to be expended on a monthly basis and in accordance with the mi via rules and program service standards.

(a) The current mi via rate schedule, available on the HSD MAD website under fee schedules, shall be used as a guide in evaluating proposed payment rates for services that are currently covered or similar to currently covered services. The participant must justify in writing the rate that he/she wishes to pay when that rate exceeds the rate schedule. The participant must include this justification with the SSP and annual budget request when it is submitted for approval.

(b) The AAB shall contain goods and services necessary for health and safety (i.e. direct care services and medically related goods) which will be given priority over goods and services that are non-medical or not directly related to health and safety. This prioritization applies to the IBA, AAB, and any subsequent modifications.

C. **SSP review criteria:** Services and related goods identified in the participant's requested SSP may be considered for approval if the following requirements are met:

(1) the services or goods must be responsive to the participant's qualifying condition or disability; and

(2) the services or goods must address the participant's clinical, functional, medical or habilitative needs; and

(3) the services or goods must accommodate the participant in managing his/her household; or

(4) the services or goods must facilitate activities of daily living; or

(5) the services or goods must promote the participant's personal health and safety; and

(6) the services or goods must afford the participant an accommodation for greater independence; and

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

(8) the services or goods must be documented in the SSP and advance the desired outcomes in the participant's SSP; and

(9) the SSP contains the quality assurance criteria to be used to determine if the service or goods meet the participant's need as related to the qualifying condition or disability; and

(10) the services or goods must decrease the need for other medicaid services; and

(11) the participant receiving the services or goods does not have the funds to purchase the services or goods; or

(12) the services or goods are not available through another source; the participant must submit documentation that the services or goods are not available through another source, such as the medicaid state plan or medicare; and

(13) the service or good is not prohibited by federal and state statutes, regulations and guidance; and

(14) each service or good must be listed as an individual line item whenever possible; when services or goods are 'bundled' the SSP must document why bundling is necessary and appropriate.

D. **Budget review criteria:** The participant's proposed annual budget request may be considered for approval, if all of the following requirements are met:

(1) the proposed annual budget request is within the participant's IBA; and

(2) the proposed rate for each service is within the mi via range of rates for that chosen service; and

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

(4) the estimated cost of the service or good is specifically documented in the participant's budget worksheets; and

(5) no employee exceeds 40 hours paid work in a consecutive seven-day period.

E. **Modification of the SSP:**

(1) The SSP may be modified based upon a change in the participant's needs or circumstances, such as a change in the participant's health status or condition or a change in the participant's support system, such as the death or disabling condition of a family member or other individual who was providing services.

(2) If the modification is to provide new or additional services than originally included in the SSP, these services must not be able to be acquired through other programs or sources. The participant must document the fact that the services are not available through another source.

(3) The participant must provide written documentation of the change in needs or circumstances as specified in the mi via service standards. The participant submits the documentation to the consultant. The consultant initiates the process to modify the SSP by forwarding the request for modification to the TPA for review.

(4) The SSP must be modified before there is any change in the AAB.

(5) The SSP may be modified once the original SSP has been submitted and approved. Only one SSP revision may be submitted at a time, e.g., an SSP revision may not be submitted if an initial SSP request or prior SSP revision request is under initial review by the TPA. This requirement also applies to any re-review or re-consideration of the same revision request. Other than for critical health and safety reasons, neither the SSP nor the AAB may be modified within 90 days of initial approval or within 60 days of expiration of the current SSP.

F. **Modifications to the annual budget:** Revisions to the AAB may occur within the SSP year, and the participant is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. The SSP must be amended first to reflect a change in the participant's needs or circumstances before any revisions to the AAB can be requested.

(1) Budget revisions involve requests to add new goods or services to a budget or to reallocate funds from any line item to another approved line item. Budget revisions must be submitted to the TPA for review and approval. Other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review during the first 90 days of the participant's budget year, or within the last 60 days of the budget year.

(2) The amount of the AAB cannot exceed the participant's annual IBA. The rare exception would be a participant whose assessed or documented needs, based on his/her qualifying condition, cannot be met within the annual IBA, in which case the participant would initiate a request for an adjustment through his/her consultant.

(3) If the participant requests an increase in his/her budget above his/her annual IBA, the participant must show one of the following circumstances:

(a) chronic physical condition: the participant has one or more chronic physical conditions, which are identified during the initial or reevaluation of the LOC, that result in a prolonged dependency on medical services or care, for which daily intervention is medically necessary; the participant's needs cannot be met within the assigned IBA or other current resources, including natural supports, medicaid state plan services, medicare or other sources; and which are characterized by at least one of the following:

(i) a life-threatening condition with frequent or constant periods of acute exacerbation that places the participant at risk for institutionalization; that could result in the participant's inability to remember to self-administer medications accurately even with the use of assistive technology devices; that requires a frequency and intensity of assistance, supervision, or consultation to ensure the participant's health and safety in the home or in the community; or which, in the absence of such skilled intervention, assistance, medical supervision or consultation, would require hospitalization or admission to an NF or ICF/MR;

(ii) the need for administration of specialized medications, enteral feeding or treatments that: are ordered by a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant; and require frequent and ongoing management or monitoring or oversight of medical technology;

(b) change in physical health status; the participant has experienced a deterioration or permanent change in her/her health status such that the participant's needs for services and supports can no longer be met within the AAB or other current resources, including natural supports, are not covered under the medicaid state plan, medicare or other sources; these are the types of changes that may necessitate an increase in the AAB; the participant now requires the administration of medications via intravenous or injections on a daily or weekly basis; the participant has experienced recent onset or increase in aspiration of saliva, foods or liquids; the participant now requires external feedings, e.g. naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube; the participant is newly dependent on a ventilator; the participant now requires suctioning every two hours, or more frequently, as needed; the participant now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; the participant now requires increased assistance with activities of daily living;

(i) the participant must submit a written, dated, and signed evaluation or letter from a medical specialist either a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant that documents the change in the participant's health status relevant to the above criteria; the evaluation or letter must have been completed since the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent;

(ii) the participant may submit additional supportive documentation by others involved in the participant's care, such as a current individual service plan if the participant is transferring from another waiver, a recent evaluation from a specialist or therapist, a recent discharge plan, relevant medical records or other documentation or recent statements from family members, friends or other support individuals;

(c) chronic or intermittent behavioral conditions or cognitive difficulties: the participant has chronic or intermittent behavioral conditions or cognitive difficulties, which are identified during the initial or reevaluation LOC assessment, or the participant has experienced a change in his/her behavioral or mental health status, for which the participant requires additional services, supports, assistance, or supervision to address the behaviors or cognitive difficulties in order to keep the participant safe; these behaviors and cognitive difficulties are so severe and intense that they result in considerable risk to the participant, caregivers or the community; require a frequency and intensity of assistance, supervision or consultation to ensure the participant's health and safety in the home or the community; are likely to lead to incarceration or admission to a hospital, NF or ICF/MR; require intensive intervention or medication management by a doctor or mental health practitioner or care practitioner; and cannot be effectively addressed within the AAB or other resources, including natural supports, the medicaid state plan, medicare or other sources;

(i) examples of chronic

or intermittent behaviors or cognitive difficulties are that the participant injuries him/herself frequently or seriously; has uncontrolled physical aggression toward others; disrupts most activities to the extent that his/her SSP cannot be implemented or routine activities of daily living cannot be carried out; withdraws personally from contact with most others; leaves or wanders away from the home, work or service delivery environment in a way that puts him/herself or others at risk;

(ii) the participant must submit a written dated and signed evaluation or letter from a medical doctor, doctor of osteopathy, certified nurse practitioner, physician's assistant, psychiatrist or psychologist with a doctorate of psychology that documents the participant's mental health or behavioral status relevant to the criteria; if the need for additional budgetary allotment is identified during the LOC assessment, it must be reflected in the assessment; if there has been a change in the participant's behaviors or cognitive difficulties, additional documentation is required; with a change in the participant's behavior or cognitive difficulties, the evaluation or letter must have been completed since the last LOC assessment or less than one year from the date the request is submitted, whichever is more recent;

(iii) the participant may submit additional supportive documentation including a current individual service plan if the participant is transferring from another waiver, a positive behavioral support plan or assessment, recent notes, a summary or letter from a mental health practitioner or professional with expertise in developmental disabilities, brain injury or geriatrics, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other support individuals involved with the participant;

(d) change in natural supports: the participant has experienced a loss, as a result of situations such as death, illness, or disabling condition, of his/her natural supports, such as family members or other community resources that were providing direct care or services, whether paid or not; this absence of natural supports or other resources is expected to continue throughout the period for which supplemental funds are requested; the type, intensity or amount of care or services previously provided by natural supports or other resources cannot be acquired within the IBA and are not available through the medicaid state plan, medicare, other programs or sources in order for the participant to live in a home and community-based setting.

(4) A mi via participant is responsible for tracking all budget expenditures and assuring that all expenditures are within the AAB. The participant must not exceed the AAB within any SSP year. A participant's failure to properly allocate the expenditures within the SSP year resulting in the depletion of the AAB, due to mismanagement of or failure to track the funds, prior to the calendared expiration date does not substantiate a claim for a budget increase (i.e, if all of the AAB is expended within the first three months of the SSP year, it is not justification for an increase in the annual budget for that SSP year). Amendments to the AAB may occur within the SSP year and the participant is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. Amendments to the AAB must be preceded by an amendment to the SSP.

(5) The AAB may be revised once the original annual budget request has been submitted and approved. Only one annual budget revision request may be submitted at a time, e.g., an annual budget revision request may not be submitted if a prior annual budget revision request is under initial review by the TPA. The same requirement also applies to any re-review or reconsideration of the same revision request.

G. **SSP and annual budget supports:** As specified in the mi via program regulations and service standards, the mi via participant is assisted by the consultant in development and implementation of the SSP and AAB. The FMA assists the participant with implementation of the AAB.

H. **Submission for approval:** The TPA must approve the SSP and associated annual budget request (resulting in an AAB). The TPA must approve certain changes in the SSP and annual budget request, as specified in the mi via program rules and service standards and in accordance with 8.302.5 NMAC, *Prior Authorization and Utilization Review.*

(1) At any point during the SSP and associated annual budget utilization review process, the TPA may request additional documentation from the participant. This request must be in writing and submitted to both the participant and the consultant provider. The participant has 15-working days from the date of the request to respond to the request for additional documentation. Failure by the participant to submit the requested information may subject the SSP and annual budget request to denial.

(2) Services cannot begin and goods may not be purchased before the start date of the approved SSP and AAB or approved revised SSP and revised AAB.

(3) Any revisions requested for other than critical health or safety reasons within the first 90 days of approval of the SSP and AAB or within 60 days of expiration of the SSP and AAB are subject to denial for that reason.

[8.314.6.17 NMAC - Rp, 8.314.6.17 NMAC, 4-1-11]

8.314.6.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services, including services covered under this waiver, are subject to utilization review for medical necessity and program requirements. Reviews by HSD/MAD or its designees may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made in accordance with 8.302.5 NMAC, *Prior Authorization and Utilization Review*.

A. **Prior authorization:** Services, supports, and goods specified in the SSP and AAB require prior authorization from HSD/MAD or its designee. The SSP must specify the type, amount and duration of services. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** To be eligible for mi via program services, participants must require the LOC of services provided in an ICF-MR for participants identified as DD and MF, or in an NF for participants identified as CoLTS (c), diagnosed with AIDS, or BI. Prior authorization of services does not guarantee that applicants/participants are eligible for medicaid.

C. **Reconsideration:** If there is a disagreement with a prior authorization denial or other review decision, the consultant provider on behalf of the participant, can request a reconsideration from the TPA that performed the initial review and issued the initial decision. A reconsideration must be requested within 30-calendar days of the date on the denial notice. Reconsideration requests must be in writing and provide additional documentation or clarifying information regarding the participant's request for the denied services or goods.

D. **Denial of payment:** If a service, support, or good is not covered under the mi via program, the claim for payment may be denied by HSD/MAD or its designee. If it is determined that a service is not covered before the claim is paid, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

[8.314.6.18 NMAC - Rp, 8.314.6.18 NMAC, 4-1-11]

8.314.6.19 REIMBURSEMENT:

A. Mi via participants must follow all billing instructions provided by the FMA to ensure payment of service providers and vendors.

B. Claims must be billed

to the FMA per the billing instructions. Reimbursement to service providers and vendors in the mi via program is made, as follows:

(1) mi via service providers and vendors must enroll with the FMA;

(2) mi via participants receive instructions and documentation forms necessary for service providers' and vendors' claims processing;

(3) mi via participants must submit claims for payment of mi via service providers and vendors to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;

(4) mi via participants and mi via service providers and vendors must follow all FMA billing instructions and those contained in 8.302 NMAC; and

(5) reimbursement of mi via service providers and vendors is made at a predetermined reimbursement rate negotiated by the participant with the service provider or vendor, approved by the TPA contractor, and documented in the SSP and in the provider/vendor agreement; at no time can the total expenditure for services exceed the participant's AAB.

C. The FMA must submit claims that have been paid by the FMA on behalf of mi via participant to the HSD/MAD fiscal contractor for processing.

D. Reimbursement may not be made directly to the participant, either to reimburse him/her for expenses incurred or to enable the participant to pay a service provider directly.

[8.314.6.19 NMAC - Rp, 8.314.6.19 NMAC, 4-1-11]

8.314.6.20 RIGHT TO A HEARING:

A. The HSD/MAD must grant an opportunity for an administrative hearing as described in this section in the following circumstances pursuant to 42 CFR Section 431.220(a)(1) and (2), NMSA 1978, Section 27-3-3 and 8.352.2 NMAC:

(1) when a mi via applicant has been determined not to meet the LOC requirement for waiver services;

(2) when a mi via applicant has not been given the choice of HCBS as an alternative to institutional care;

(3) when a mi via applicant is denied the services of his/her choice or the provider of his/her choice;

(4) when a mi via participant's services are denied, suspended, reduced or terminated;

(5) when a mi via participant has been involuntarily terminated from the program;

(6) when a mi via participant's request for a budget adjustment has been denied.

B. ALTSD and its counsel, if necessary, shall participate in any fair hearing involving a disabled or elderly participant, or a participant diagnosed with BI. DOH and its counsel, if necessary, shall participate in any fair hearing involving a DD or MF participant, or a participant diagnosed with AIDS. HSD/MAD, and its counsel, if necessary, may participate in fair hearings.

[8.314.6.20 NMAC - N, 4-1-11]

8.314.6.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to participants who request a hearing within 13 calendar days of the notice. The notice will include information on the right to continued benefits and on the participant's responsibility for repayment if the hearing decision is not in the participant's favor.

B. Once a participant requests a continuation of benefits, his/her AAB that is in place at the time of the request is termed a continuation budget. The continuation budget may not be revised until the conclusion of the fair hearing process unless one of the criteria to modify the budget in Paragraph (3) of Subsection F of 8.314.6.17 NMAC is met.

[8.314.6.21 NMAC - N, 4-1-11]

8.314.6.22 GRIEVANCE/COMPLAINT SYSTEM: The HSD/MAD, DOH and ALTSD operate a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under the mi via program. Any mi via participant may file a grievance with HSD/MAD.

A. ALTSD/EDSD administers the grievance/complaint process for participants in the NF waiver. Participants may register complaints with ALTSD/EDSD via e-mail, mail or phone. Participants can also register a complaint with HSD/MAD or DOH/DDSD, which is then referred to ALTSD/EDSD. The participant is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.

(1) A grievance or complaint is required to be resolved within 30 days from the date it was received.

(2) Upon receipt of the grievance or complaint, ALTSD enters it into the complaint tracker and informs the contractor or provider of the grievance or complaint. ALTSD/EDSD notifies the participant within one day of receipt of the grievance or complaint who will be responsible for resolution of the grievance or complaint.

(3) ALTSD/EDSD gives the contractor or provider 14 days to resolve the grievance or complaint. If the grievance or complaint contains an issue that may compromise the health or safety of the participant, ALTSD/EDSD remains involved with the parties until the grievance or complaint is resolved.

(4) The contractor or provider shall notify ALTSD/EDSD of their progress toward resolution of the grievance or complaint. If the grievance or complaint has not been resolved in 14 days, ALTSD/EDSD becomes involved to ensure that resolution occurs within 30 days of receipt of the grievance or complaint.

B. Participants in the ICF/MR waiver may register a complaint or grievance about any program issue with which they are dissatisfied. Participants may register complaints with DOH/DDSD via e-mail, mail, or by phone. The DOH/DDSD utilizes a standardized complaint form and has established a dedicated e-mail address to register complaints. Participants can also register complaints with the ALTSD/EDSD, and HSD/MAD, which is then referred to DOH/DDSD. The participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

(1) The complaint/grievance is required to be resolved within 14 days from the date the complaint/grievance was filed by the participant.

(2) Upon receipt of the complaint/grievance, the complaint is entered into the complaint tracker by DOH/DDSD and the appropriate contractor/provider is e-mailed the nature of the complaint/grievance to begin the resolution process.

(3) The participant is contacted within one business day from the date the complaint/grievance is received by DOH/DDSD to acknowledge receipt of the complaint/grievance.

(4) On either the fifth or tenth day after the filing of the complaint, the DOH/DDSD follows up with the contractor/provider on the status of the complaint/grievance. The DOH/DDSD enters the status information into the complaint tracker.

(5) No later than the 14th day after the complaint was filed, the contractor/provider is required to e-mail the resolution to the DOH/DDSD. The date the e-mail is sent to DOH/DDSD is the date the complaint/grievance is resolved. Once received, the DOH/DDSD enters the resolution into the complaint tracker and calls the participant to verify that resolution occurred. The conversation with the participant is documented into the complaint tracker.

(6) Contractor/providers may request extensions to resolve issues at least three days prior to the 14-day deadline. Extensions to resolve complaints must occur via e-mail to DOH/DDSD. DOH/DDSD will grant or deny extensions within one business day. If approved by DOH/DDSD, extensions will be granted for an additional

14 days.
[8.314.6.22 NMAC - N, 4-1-11]

History of 8.314.6 NMAC:

History of Repealed Material:
8.314.6 MAC, Mi Via Home and Community-Based Services Waiver, filed 11-16-2006 - Repealed effective 4-1-2011

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.200.520 NMAC, Sections 11 and 13, effective April 1, 2011.

8.200.520.11 FEDERAL POVERTY INCOME GUIDELINES:

A. **100% of federal poverty:** 100% of federal poverty income guidelines

Size of assistance unit	Poverty income guidelines
1	[~~$903~~] $908 per month*
2	[~~$1,215~~] $1,226 per month*
3	[~~$1,526~~] $1,545 per month
4	[~~$1,838~~] $1,863 per month
5	[~~$2,150~~] $2,181 per month
6	[~~$2,461~~] $2,500 per month
7	[~~$2,773~~] $2,818 per month
8	[~~$3,085~~] $3,136 per month

Add [~~$312~~] $318 for each additional person in the assistance unit.
*Use only these two standards for the QMB program.

B. **120% of federal poverty:** This income level is used only in the determination of the maximum income limit for specified low income medicare beneficiaries (SLIMB) applicants/recipients.

Applicant/recipient	Amount
1. Individual	At least [~~$903~~] $908 per month but no more than [~~$1,083~~] $1,089 per month.
2. Couple	At least [~~$1,215~~] $1,226 per month but no more than [~~$1,457~~] $1,471 per month.

For purposes of this eligibility calculation, couple means an applicant couple or an applicant with an ineligible spouse when income is deemed.

C. **133% of federal poverty:** 133% of federal poverty income guidelines

Size of assistance unit	Poverty income guidelines
1	[~~$1,201~~] $1,207 per month
2	[~~$1,615~~] $1,631 per month
3	[~~$2,030~~] $2,054 per month
4	[~~$2,444~~] $2,478 per month
5	[~~$2,859~~] $2,901 per month
6	[~~$3,273~~] $3,324 per month
7	[~~$3,688~~] $3,748 per month
8	[~~$4,102~~] $4,171 per month

Add [~~$414~~] $423 for each additional person in the assistance unit.

D. **135% of federal poverty:** This income level is used only in the determination of the maximum income limit for qualified individuals 1 (QI-1) applicants/recipients. The following income levels apply:

Applicant/recipient	Amount
1. Individual	At least [~~$1,083~~] $1,089 per month but no more than [~~$1,219~~] $1,226 per month.
2. Couple	At least [~~$1,457~~] $1,471 per month but no more than [~~$1,640~~] $1,655 per month.

For purposes of this eligibility calculation, couple means an applicant couple or an applicant with an ineligible spouse when income is deemed.

E. **150% of federal poverty:** This income level is used only in the determination of the maximum income limit for state coverage insurance (SCI) (category 062) applicants/recipients. The following income levels apply:

Size of assistance unit	Poverty income guidelines
1	[~~$1,354~~] $1,362 per month
2	[~~$1,822~~] $1,839 per month
3	[~~$2,289~~] $2,317 per month
4	[~~$2,757~~] $2,794 per month
5	[~~$3,224~~] $3,272 per month
6	[~~$3,692~~] $3,749 per month
7	[~~$4,159~~] $4,227 per month
8	[~~$4,627~~] $4,704 per month

Add [~~$468~~] $477 for each additional person in the assistance unit.

F. **185% of federal poverty:**

Size of assistance unit	Poverty income guidelines
1	[~~$1,670~~] $1,679 per month

2	[~~$2,247~~] $2,268 per month
3	[~~$2,823~~] $2,857 per month
4	[~~$3,400~~] $3,446 per month
5	[~~$3,976~~] $4,035 per month
6	[~~$4,553~~] $4,624 per month
7	[~~$5,130~~] $5,213 per month
8	[~~$5,706~~] $5,802 per month

Add [~~$576~~] $589 for each additional person in the assistance unit.

G. **200% of federal poverty:** 200% of federal poverty income guidelines

Size of assistance unit	Poverty income guidelines
1	[~~$1,805~~] $1,815 per month
2	[~~$2,429~~] $2,452 per month
3	[~~$3,052~~] $3,089 per month
4	[~~$3,675~~] $3,725 per month
5	[~~$4,299~~] $4,362 per month
6	[~~$4,922~~] $4,999 per month
7	[~~$5,545~~] $5,635 per month
8	[~~$6,169~~] $6,272 per month

Add [~~$624~~] $637 for each additional person in the assistance unit.

H. **235% of federal poverty:** 235% of federal poverty income guidelines

Size of assistance unit	Poverty income guidelines
1	[~~$2,123~~] $2,134 per month
2	[~~$2,856~~] $2,882 per month
3	[~~$3,587~~] $3,631 per month
4	[~~$4,320~~] $4,379 per month
5	[~~$5,053~~] $5,126 per month
6	[~~$5,784~~] $5,875 per month
7	[~~$6,517~~] $6,623 per month
8	[~~$7,250~~] $7,370 per month

Add [~~$733~~] $747 for each additional person in the assistance unit.

I. **250% of federal poverty:** 250% of federal poverty income guidelines

Size of assistance unit	Poverty income guidelines
1	[~~$2,257~~] $2,269 per month
2	[~~$3,036~~] $3,065 per month
3	[~~$3,815~~] $3,861 per month
4	[~~$4,594~~] $4,657 per month
5	[~~$5,373~~] $5,453 per month
6	[~~$6,153~~] $6,248 per month
7	[~~$6,932~~] $7,044 per month
8	[~~$7,711~~] $7,840 per month

Add [~~$779~~] $796 for each additional person in the assistance unit.

[1-1-95, 4-1-95, 4-15-96, 4-1-97, 3-31-98, 3-1-99, 4-1-99, 4-1-00; 8.200.520.11 NMAC - Rn, 8 NMAC 4.MAD.520.1-5, & 14, & A, 1-1-01; A, 4-1-01; A, 4-1-02; A, 4-1-03; A, 4-1-04; A, 4-1-05; A, 4-1-06; A, 4-1-07; A, 4-1-08; A, 4-1-09; A, 4-1-11]

8.200.520.13 FEDERAL BENEFIT RATES

YEAR	Individual	Inst.	Indiv.	Couple	Inst.	Couple
	FBR	FBR	VTR	FBR	FBR	VTR
1/89 to 1/90	$368	$30	$122.66	$553	$60	$184.33
1/90 to 1/91	$386	$30	$128.66	$579	$60	$193.00
1/91 to 1/92	$407	$30	$135.66	$610	$60	$203.33
1/92 to 1/93	$422	$30	$140.66	$633	$60	$211.00
1/93 to 1/94	$434	$30	$144.66	$652	$60	$217.33
1/94 to 1/95	$446	$30	$148.66	$669	$60	$223.00
1/95 to 1/96	$458	$30	$152.66	$687	$60	$229.00
1/96 to 1/97	$470	$30	$156.66	$705	$60	$235.00
1/97 to 1/98	$484	$30	$161.33	$726	$60	$242.00
1/98 to 1/99	$494	$30	$164.66	$741	$60	$247.00
1/99 to 1/00	$500	$30	$166.66	$751	$60	$250.33
1/00 to 1/01	$512	$30	$170.66	$769	$60	$256.33
1/01 to 1/02	$530	$30	$176.66	$796	$60	$265.33
1/02 to 1/03	$545	$30	$181.66	$817	$60	$272.33
1/03 to 1/04	$552	$30	$184.00	$829	$60	$276.33

1/04 to 1/05	$564	$30	$188	$846	$60	$282.00
1/05 to 1/06	$579	$30	$193	$869	$60	$289.66
1/06 to 1/07	$603	$30	$201	$904	$60	$301.33
1/07 to 1/08	$623	$30	$207.66	$934	$60	$311.33
1/08 to 1/09	$637	$30	$212.33	$956	$60	$318.66
1/09 to 1/10	$674	$30	$224.66	$1,011	$60	$337
1/10 to 1/11	$674	$30	$224.66	$1,011	$60	$337
1/11 to 1/12	$674	$30	$224.66	$1,011	$60	$337

Ineligible child deeming allocation: $319.00

Part B premium is [~~$96.40~~] $115.40 per month.

VTR (value of one third reduction) is used when an individual or couple lives in the household of another and receives food and shelter from the household or when the individual or couple is living in their own household but receiving support and maintenance from others.

The SSI resource standard is $2000 for an individual and $3000 for a couple.

[1-1-95, 4-1-95, 3-30-96, 4-1-97, 4-30-98, 1-1-99; 8.200.520.13 NMAC - Rn, 8 NMAC 4.MAD.520.7 & A, 1-1-01; A, 1-01-02; A, 1-1-03; A, 1-1-04; A, 1-1-05; A, 1-1-06; A, 1-1-07; A, 1-1-08, A, 1-1-09; A, 1-15-10; A, 1-1-11; A, 4-1-11]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

Explanatory paragraph: This is an amendment to 8.310.5 NMAC, Section 15, which will be effective April 1, 2011. The Medical Assistance Division is amending Subsections D and E, striking references to a unit for risk, variable time units and risk factors and clarifying language for reimbursement for anesthesiology residents, CRNAs and AAs who are medically directed.

8.310.5.15 REIMBURSEMENT:

D. **Reimbursement units:** Reimbursement for anesthesia services is calculated using the MAD fee schedule anesthesia "base units" plus units for time [~~and units for risk~~].

(1) Each anesthesia procedure is assigned a specific number of relative value units which becomes the "base unit" for the procedure. Units of time are also allowed for the procedure. Reimbursement is calculated by multiplying the total number of units by the conversion factor allowed for each unit.

(2) The reimbursement per anesthesia unit varies depending on who furnishes the service. Separate rates are established for a physician anesthesiologist, a medically-directed certified registered nurse anesthetist (CRNA), anesthesiology assistant (AA) and a non-directed CRNA.

(3) [~~Time units vary, depending on the service.~~] For anesthesia provided directly by a physician anesthesiologist, CRNA, or an anesthesiology assistant, one time unit is allowed for each 15- minute period an eligible recipient is under anesthesia. For medical direction, one time unit is allowed for each 15- minute period.

[~~(4) Risk factor modifiers are used to describe the relative risk associated with general anesthesia to a particular recipient. Performing anesthesia providers are reimbursed for additional units only if risk factor modifiers are indicated on the claim.~~]

E. **Medical direction:** [~~Medical direction by a physician anesthesiologist, not the surgeon or assistant surgeon, to a certified registered nurse anesthetist (CRNA) or an anesthesiology assistant (AA) is paid on the basis of 50 percent of the allowance for the service performed by the physician alone.~~] Reimbursement is made at 50 percent of the full anesthesia service amount for medical direction by a physician anesthesiologist who is not the surgeon or assistant surgeon, for directing an anesthesia resident, a registered nurse anesthetist (CRNA) or an anesthesiology assistant (AA). Reimbursement is made at 50 percent of the full anesthesia service amount for the anesthesia service provided by the medically directed anesthesiology resident, CRNA or AA. Medical direction occurs if the physician medically directs qualified practitioners in two, three, or four concurrent cases and the physician performs the activities described below. Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving an eligible recipient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-eligible recipients and the remaining a MAD eligible recipient, this represents three concurrent cases.

(1) Time units for medical direction are allowed at one time unit for each 15- minute interval.

(2) Anesthesia claims are not payable if the surgery is not a medicaid benefit or if any required documentation was not obtained.

(3) Medical direction is a covered service only if the physician:

(a) performs a pre-anesthesia examination and evaluation; and

(b) prescribes the anesthesia plan; and

(c) personally participates in the most demanding procedures of the anesthesia plan including induction and emergence; and

(d) ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified anesthetist; and

(e) monitors the course of anesthesia administration at frequent intervals; and

(f) remains physically present and available for immediate diagnosis and treatment of emergencies; and

(g) provides indicated post-anesthesia care.

(4) For medical direction, the physician must document in the medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures, including induction and emergence, where indicated.

(5) A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients may not ordinarily be involved in furnishing additional services to other patients. Addressing an emergency of short duration in the immediate

area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. Medical direction criteria are met even though the physician responds to an emergency of short duration.

(6) While directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

(7) If a physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patient, the physician's services to the surgical patients are supervisory in nature. Medical direction cannot be billed.

[2/1/95; 8.310.5.15 NMAC - Rn, 8 NMAC 4.MAD.714.6 & A, 6/1/03; A, 11/1/10; A, 4/1/11]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.311.3 NMAC, Sections 3, 5, 6, 8 and 10-15, effective April 1, 2011.

8.311.3.3 STATUTORY AUTHORITY: [~~The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991).~~] 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 the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.

[2-1-95; 8.311.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 1-1-01; A, 4-1-11]

8.311.3.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.

[2-1-95; 8.311.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 1-1-01; A, 4-1-11]

8.311.3.6 OBJECTIVE: [~~The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.~~] The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.

[2-1-95; 8.311.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 1-1-01; A, 4-1-11]

8.311.3.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.

[2-1-95; 8.311.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 1-1-01; A, 4-1-11]

8.311.3.10 GENERAL REIMBURSEMENT POLICY: The state of New Mexico human services department (hereinafter called the department) will reimburse inpatient hospital services rendered on or after October 1, 1989 in the following manner:

A. Covered inpatient services provided to eligible [~~medicaid~~] recipients admitted to in-state acute care hospitals and acute care units on or after October 1, 1989 will be reimbursed at a prospectively set rate, determined by the methodology set forth in 8.311.3.12 NMAC [~~of this part~~], unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsection C through [~~E~~] D below.

B. [~~Covered inpatient services provided to eligible recipients in the New Mexico medicaid program, when treated in border area hospitals (i.e., those hospital located within 100 miles of the New Mexico border, Mexico excluded) will be reimbursement at a prospectively set rate as described in 8.311.3.12.C.(16) NMAC of this part.~~] Covered inpatient services provided to eligible recipients admitted to acute care hospitals and acute care units within hospitals located out of state or in border areas (Mexico excluded) will be reimbursed at a prospectively set rate as described in Paragraph (16) of Subsection C of 8.311.12 NMAC , unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsections C through D below or at a negotiated rate not to exceed the rate paid by federal programs such as medicare. Negotiation of rates will only be allowed when the department determines that the hospital provides an unique service required by an eligible recipient.

C. Inpatient services provided in rehabilitation and [~~children's~~] specialty hospitals and medicare PPS-exempt distinct part units within hospitals will be reimbursed using the provisions and principles of reimbursement set forth in Public Law 97-248. This legislation, which was effective October 1, 1982, is commonly referred to as TEFRA (Tax Equity and Finance Reduction Act) and is described in 8.311.3.11 NMAC of this section. [~~Pediatric, psychiatric, substance abuse and rehabilitation cases treated in non-exempt general be included in the PPS.~~]

D. Indian health services hospitals will be reimbursed using a per diem rate established by the federal government.

[~~E. Covered inpatient services provided by out-of-state hospitals (i.e., those hospital located more than 100 miles from the New Mexico border, Mexico excluded) will be reimbursed on a percent of charge basis. All non-border out of state hospital claims will be reimbursed at a rate consisting of 70 percent of the provider's allowable charges. Covered inpatient services provided in specialty hospitals and medicare PPS-exempt distinct part units within hospitals will be reimbursed at 70 percent of billed charges or a negotiated rate, not to exceed the rate paid by federal programs such as CHAMPUS or medicare. Negotiation of rates will only be allowed when the department determines that the specialty hospital or specialty unit provides a unique service required by medicaid recipients.~~

~~F.~~] E. New Mexico providers entering the [~~medicaid~~] MAD program will be reimbursed at the peer group median rate for the applicable peer group, until such time as [~~rebasing occurs~~] a distinct rate can be established, unless the hospital meets the criteria for prospective payment exemption as described in Subsections C through [~~E~~] D above.

[~~G.~~] F. All hospitals which meet the criteria in [~~8.311.3.13.A. NMAC of this part~~] Subsection A of 8.311.3.13 NMAC will be eligible for a disproportionate share adjustment.

[~~H.~~] G. Effective for discharges on or after April 1, 1992, and in accordance with Section 4604 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the department provides for an outlier adjustment in payment amounts for medically necessary inpatient services involving exceptionally high costs or long lengths of stay for children who have not attained the age of six years in disproportionate share hospitals and for infants under [~~age one~~] one year of age in all hospitals. The outlier adjustment for these cases is described in Subsection F of 8.311.3.12 NMAC [~~of this part~~].

[2-1-95; 8.311.3.10 NMAC - Rn, 8 NMAC 4.MAD.721.D.I, 1-1-01; A, 4-1-11]

8.311.3.11 PAYMENT METHODOLOGY FOR PPS-EXEMPT HOSPITALS AND EXEMPT UNITS WITHIN HOSPITALS

A. **Application of TEFRA principles of reimbursement:**

(1) The principles and methods identified in Public Law 97-248 provision (TEFRA), effective October 1, 1982, regarding allowable payment for inpatient hospital services, and any subsequent changes to such provision shall be used to determine:

(a) the amount payable by the department through its fiscal agent for services covered under the [~~medical assistance~~] MAD program and provided to [~~title XIX~~] eligible recipients; and

(b) the manner of payment and the manner of settlement or overpayments and underpayment for inpatient services provided by hospitals for [~~Title XIX~~] MAD reimbursement purposes, effective for all accounting periods which begin on or after October 1, 1983.

(2) The inflation factor used in the calculations will be identical to that used by medicare to update payments to hospitals which are reimbursed using the TEFRA methodology, except for the period October 9, 1991, through September 30, 1992, for which the inflation factor will be .5[%] percent for urban hospitals and 1.5[%] percent for rural hospitals.

(3) In accordance with Section 1902 (s)(3) of the Social Security Act effective July 1, 1991, the TEFRA rate of increase limit for inpatient hospital services will not apply to the delivery of such services to any individual who has not attained their first birthday, (or in the case of such a individual who is an inpatient on his first birthday until such individual is discharged).

B. **Appeals:**

(1) Hospitals may appeal the target rate and application of same, if circumstances beyond the hospitals' control have caused the reimbursement rates to fall at least five percent below actual allowable costs.

(2) Such appeals must be filed in writing within 180 calendar days of the notice of final settlement and must contain sufficient supporting documentation to demonstrate that the circumstances causing the situation were not within the control of the hospital and that the continued imposition of the target rate would cause a significant financial hardship.

(3) The department shall review the supporting documentation and, if appropriate, grant an exemption from or modification of the target rate. The department's determination on the merits of the appeal will be made within 180 calendar days of receipt of the appeal request, although the state may make a determination to extend such period to a specified date as necessary.

[2-1-95; 8.311.3.11 NMAC - Rn, 8 NMAC 4.MAD.721.D.II, 1-1-01; A, 4-1-11]

8.311.3.12 PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS: Payment for all covered inpatient services rendered to [~~Title XIX~~] eligible recipients admitted to acute care hospitals (other than those identified in Subsection C through [~~E~~] D of 8.311.3.10 NMAC) on or after October 1, 1989 shall be made based on a prospective payment approach which compensates hospitals an amount per discharge for discharges classified according to the diagnosis related group (DRG) methodology. The prospective rates for each hospital's [~~medicaid~~] MAD discharges will be determined by the department in the manner described in the following subsections.

A. **Services included in or excluded from the prospective payment rate:**

(1) Prospective payment rates shall constitute payment in full for each [~~medicaid~~] MAD discharge. Hospitals may not separately bill the [~~patient~~] eligible recipient or the [~~medicaid~~] MAD program for medical services rendered during an inpatient stay, except as described below. Hospitals may submit a claim for payment only upon the final discharge of [~~a patient~~] an eligible recipient or upon completion of the transfer of the [~~patient~~] eligible recipient to another acute care hospital.

(2) The prospective payment rate shall include all services provided to hospital inpatients. These services shall include all items and non-physician services furnished directly or indirectly to hospital inpatients, such as:

(a) laboratory services;

(b) pacemakers and other prosthetic devices, including lenses and artificial limbs, knees and hips;

(c) radiology services, including computed tomography (CT) or magnetic resonance imaging (MRI) scans furnished to [~~patients~~] an eligible recipient by a physician's office, other hospital or radiology clinic;

(d) transportation (including transportation by ambulance) to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services.

(3) Services which may be billed separately include:

(a) ambulance service when the [~~patient~~] eligible recipient is transferred from one hospital to another and is admitted as an inpatient to the second hospital;

(b) physician services furnished to [~~individual patients~~] an individual eligible recipient.

B. **Computation of DRG relative weights:**

(1) Relative weights used for determining rates for cases paid by DRG under the state plan shall be derived, to the greatest extent possible, from New Mexico [~~medicaid~~] MAD hospital claim data. All such claims are included in the relative weight computation, except as described below.

(2) Hospital claim data for discharges occurring from January 1, 1985 through approximately the end of calendar year 1988 are included in the computation and prepared as follows:

(a) Claims are edited to merge interim bills from the same discharge.

(b) All [~~medicaid~~] MAD inpatient discharges will be classified using the DRG methodology, a patient classification system that reflects clinically cohesive groupings of inpatient cases which consume similar amounts of hospital resources. Claims are assigned to appropriate DRGs using [~~version 6.0 of the health systems international~~] DRG grouper software.

(c) Claims included in the computation of DRG relative weights were restricted to those claims for cases to be included in the proposed PPS. Claims for services provided in PPS-exempt hospitals or units (or for services otherwise exempt from the PPS) were not used to compute DRG relative weights.

(3) Charges for varying years are adjusted to represent a common year through application of inflation indices as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

(4) Initial relative weights are computed by calculation of the average [~~medicaid~~] MAD charge for each DRG category divided by the average charge for all DRGs.

(5) Where the New Mexico [~~medicaid~~] MAD-specific claims and charge data are insufficient to establish a stable relative weight, a relative weight is imported from other sources such as the CHAMPUS or medicare prospective payment systems. Weights obtained from external sources are normalized so that the overall case mix is 1.0.

(6) The relative weights computed as described above shall remain in effect until the next year. At that time, the relative weights will be recalculated using [~~whatever~~] the DRG grouper version [~~is currently~~] similar to the one in use by medicare.

C. **Computation of hospital prospective payment rates:**

(1) **Rebasing of rates:** Beginning October 1, 1997 the department [~~has~~] discontinued the rebasing of rates every

three years. Hospital rates in effect October 1, 1996 were updated by the most current market basket index (MBI) as determined by the centers for medicare and medicaid services (CMS) for rates effective October 1, 1997 and succeeding years. Thereafter, pursuant to budget availability and at the department's discretion, the application of the MBI inflation factor will be reviewed based upon economic conditions and trends. A notice will be sent out every October 1st, informing the provider whether the MBI will be used for the upcoming year and what the percentage increase will be if the MBI or a percentage up to the MBI is authorized to be applied.

(2) **Base year discharge and cost data:**

(a) The state's fiscal agent will provide the department with [~~title XIX~~] MAD discharges for the provider's last fiscal year which falls in the calendar year prior to year [~~1~~] one.

(b) The state's audit agent will provide [~~title XIX~~] MAD costs incurred, reported, audited, [~~and/or~~] or desk audited for the same period.

(c) To calculate the total reimbursable inpatient operating costs from the cost and discharge data described above, the department will:

(i) exclude estimated outlier discharges and costs as described in Paragraph (4) of Subsection C of 8.311.3.12 NMAC [~~of this part~~];

(ii) exclude pass-through costs, as identified in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provisions and further defined in Paragraph (3) of Subsection C of 8.311.3.12 NMAC below.

(3) **Definition of excludable costs per discharge; reduction of excludable capital costs:**

(a) The approach used by the department to define excludable costs parallels medicare's approach. Excludable costs are defined according to the PPS or TEFRA methodology and include such costs as those associated with capital, organ acquisition, and certified nurse anesthetists.

(b) The pass-through capital costs identified using TEFRA provisions will be reduced in a manner similar to that employed by the medicare PPS. For example, excludable capital costs for fiscal year 1989 will be reduced by 15 percent as required by Section 4006 of the Omnibus Budget Reconciliation Act of 1987. However, any such reduction to pass-through capital costs will only apply to those costs incurred after October 1, 1989.

(4) **Outlier adjustment factors:** Hospital-specific outlier adjustment factors will be used to deduct outlier costs and cases from the total [~~medicaid~~] MAD inpatient operating costs and cases used in rate setting. These factors will be determined by using actual claim and cost data for outlier cases for the base year period. Only claims for cases to be paid by DRG will be included in the analysis used to determine this estimate. The definition of an outlier case can be found in Paragraph (1) of Subsection F of 8.311.3.12 NMAC [~~of this part~~].

(5) **Calculation of base year operating cost per discharge:** The total reimbursable inpatient operating cost (excluding pass-through costs and estimated outlier costs) is divided by the hospital's number of non-outlier [~~medicaid~~] MAD discharges to produce the base year operating cost per discharge. The base rate methodology is described below:

BYOR = [~~OC~~ ~~D~~] OC/D

BYOR = base year operating cost per discharge

OC = total Title XIX inpatient operating cost for the base year, less excludable costs and estimated outlier costs

D = [~~medicaid~~] MAD discharges for the hospital's base year as provided by the department's fiscal agent, less estimated outlier cases.

(6) **Possible use of interim base year operating cost per discharge rate:**

(a) If the fiscal agent and audit agent have not provided the department with a hospital's base year discharges and costs as of June 1 prior to year [~~1~~] one, the department will develop an interim operating cost per discharge base rate. This rate will be developed according to the normal base rate methodology, but using costs and discharges for the fiscal year prior to the base year.

(b) When an interim rate is developed, the operating costs per discharge are first multiplied by an inflation index (as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC [~~of this part~~]) to bring the costs to the midpoint of the base year. When the provider's actual base year costs and discharges become available, the department will calculate a final base year operating cost per discharge using the normal base rate methodology. The rate that is computed from the final base year operating costs per discharge will apply to all discharges in year [~~1~~] one, retroactive to the effective date of the interim rate.

(7) **Prohibition against substitution or rearrangement of base year cost reports:**

(a) A hospital's base year cost reports cannot be substituted or rearranged once the department has determined that the actual cost submission is suitable. A submission shall be deemed suitable 180 calendar days from the date of the notice of proposed rate (NPR) issued by the state's intermediary in the absence of an appeal by the hospital to the intermediary and the state.

(b) In the event of such an appeal, the state must make a written determination on the merits of the appeal within 180 calendar days of receipt, although the state may make a determination to extend such period to a specified date as necessary. Once such an appeal has been determined, the resulting base cost will be effective retroactively to year [~~1~~] one and will not be changed until subsequent rebasing of all hospitals has been completed.

(8) **Application of inflation factors:**

(a) The inflation factors used to update operating costs per discharge will be identical to those established by congress and adopted for use by [~~the centers for medicaid and medicare services (CMS)~~] CMS to update medicare inpatient prospective payment rates. The medicare prospective payment update factor (MPPUF) is determined by CMS, usually on an annual basis, and may differ depending upon the hospital type (urban, large urban, or rural) as defined by CMS.

(b) Each hospital's base year operating cost per discharge will be indexed up to the common point of December 31 falling prior to year [~~1~~] one, using the applicable medicare prospective payment update factors (MPPUF) for that hospital for that period. That is, the inflation factors used will be identical to those established by congress and adopted for use by CMS to update medicare inpatient prospective payment rates, including any established differential for urban and rural hospitals. Then this value will be indexed using the applicable MPPUF corresponding to the period beginning October 1 (prior to year [~~1~~] one) and ending with the midpoint of operating year [~~1~~] one. For years [~~2 and 3~~] two and three, the inflation factors will be the applicable MPPUF as specified by CMS.

(c) For the period October 9, 1991, through September 30, 1992, an exception to (a) and (b) above was made. The inflation factor used to update rates for that period is .5[%] percent for urban hospitals and 1.5[%] percent for rural hospitals.

(9) **Case-mix adjustments for base year operating cost per discharge rate:**

(a) The department will adjust the operating cost per discharge rate to account for case-mix changes, based on the classification of inpatient hospital discharges according to the DRG methodology established and used by the medicare program.

(b) For each DRG, the department determines a relative value (the DRG relative weight) which reflects the charges for hospital resources used for the DRG relative to the average charges of all hospital cases. The department's methodology for computing DRG relative weights

was discussed earlier in Subsection B of 8.311.3.12 NMAC. Case-mix adjustments will be computed using the methodology described below:

(c) **Case-mix computation:** Each base year, a hospital's case-mix index will be computed by the department and its fiscal agent as follows:

(i) All [~~title XIX~~] MAD discharges are assigned to appropriate DRGs.

(ii) The case-mix index is computed for each hospital by summing the products of the case frequency and its DRG weight and dividing this sum by the total number of title XIX cases at the hospital.

(d) The case-mix adjustment is applied to the base year operating cost per discharge as described in Subparagraph (e) of Paragraph (10) of Subsection C of 8.311.3.12 NMAC below.

(10) **Limitations on operating cost prospective per discharge rates:**

(a) Limitations on operating cost prospective base rates will be imposed using a peer group methodology. Effective October 1, 1989, hospitals will be placed in one of six possible peer groups (teaching, referral, regional, low-volume regional, community and low-volume community) based on the following criteria: bed size, case-mix, services available, population served, location, trauma designation, teaching status, and low-volume (i.e. less than 150 [~~medicaid~~] MAD discharges per year.)

(b) At the time of the next rebasing year following October 1, 1989, the criteria regarding low-volume utilization was dropped along with the low-volume peer groups, thus leaving four possible peer groups for assignment (teaching, referral, regional and community).

(c) The department will determine the peer group assignment of each hospital, and appeal of such assignment will be allowed only as described in Paragraph (1) of Subsection D of 8.311.3.12 NMAC [~~of this part~~].

(d) A ceiling on allowable operating costs will be set at 110 percent of the median of costs for all hospitals in the peer group, after application of each hospital's case mix and indexing of the cost from the hospital's fiscal year end to a common point of December 31. These adjustments are made to equalize the status of each hospital for ceiling establishment purposes. The median shall be the midpoint of rates (or the average of the rates of the two hospitals closest to the midpoint).

(e) The case-mix equalization for each hospital in a peer group will be calculated as follows:

PGR = BYOR/CMI

PGR = hospital rate equalized for peer group comparison

BYOR = base year operating cost per discharge

CMI = case-mix index in the base year

(f) The allowable operating cost per discharge rate (hospital-specific rate) will be the lower of:

(i) the ceiling for the hospital's peer group; or

(ii) the hospital rate resulting from the computation found in Subparagraph (e) of Paragraph (10) of Subsection C of 8.311.3.12 NMAC above.

(11) **Computation of prospective operating cost per discharge rate:** The following formulas are used to determine the prospective operating cost per discharge rate for years [~~1, 2, and 3~~] one, two and three:

Year [~~1~~]one

[~~PD01~~] PDO1 = HSR x (1 + MPPUF)

[~~PD01~~] PDO1 = per discharge operating cost rate for year [~~1~~] one

HSR = the hospital-specific rate, which is the lower of the peer group ceiling or the hospital's rate, equalized for peer group comparison

MPPUF = the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

Year [~~2~~] two

PDO2 = PDO1 x (1 + MPPUF)

PDO2 = per discharge operating cost rate for year [~~2~~] two

PDO1 = per discharge operating cost rate for year [~~1~~] one

MPPUF = the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

Year [~~3~~] three

PDO3 = PDO2 x (1 + MPPUF)

PDO3 = per discharge operating cost rate for year [~~3~~] three

PDO2 = per discharge operating cost rate for year [~~2~~] two

MPPUF = the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

(12) **Computation of excludable cost per discharge rate:** Total [~~medicaid~~] MAD excludable cost, as identified in TEFRA, with excludable capital costs reduced as indicated in Paragraph (3) of Subsection C of 8.311.3.12 NMAC, will be paid in the following manner:

(a) An excludable cost per discharge rate is computed using the following methodology:

ER = ECP/DCY

ER = excludable cost per discharge rate

ECP = excludable costs on the hospital's most recently settled cost report prior to the rate year, as determined by the audit agent

DCY = [~~medicaid~~] MAD discharges for the calendar year prior to the rate year, as determined by the department's fiscal agent

(b) The retrospective settlement will be determined based on a percentage of the actual allowable amount of [~~medicaid~~] MAD excludable costs incurred by a hospital during the hospital's fiscal year as determined by the department.

(13) **Computation of prospective per discharge rate:** The excludable cost per discharge, as described in Paragraph (12) of Subsection C of 8.311.3.12 NMAC above, will be added to the appropriate operating per discharge rates to determine the prospective rates.

(14) **Effective dates of prospective rates:** Rates were implemented October 1, 1989 and continue to be effective as of October 1 of each year for each hospital.

(15) **Effect on prospective payment rates of a change of hospital ownership:** When a hospital is sold or leased, no change is made to the hospital's per discharge rate as a result of the sale or lease transaction.

(16) **Rate setting for border-area hospitals:** Border-area hospitals will be reimbursed at median rate (including excludable cost pass-throughs) for the regional peer group.

D. **Changes to prospective rates:**

(1) **Appeals:** Hospitals may appeal for a change in the operating component of the prospective payment rate, including a change in peer group assignment, as applicable. For an appeal to be considered, the hospital must demonstrate in the appeal that:

(a) the following five requirements are satisfied:

(i) the hospital inpatient service mix for [~~medicaid~~] MAD admissions has changed due to a major change in scope of facilities and services provided by the hospital;

(ii) the change in scope of facilities and services has satisfied all regulatory and statutory requirements which may be applicable, such as facility licensure and certification requirements and any other facility or services requirements which might apply;

(iii) the expanded services were a) not available to [~~medicaid patients~~] eligible recipients in the area or b) are now provided to [~~medicaid patients~~] eligible recipients by the hospital at a lower reimbursement rate than would be obtained in other hospitals providing the service;

(iv) the magnitude of the proposed (as appealed) prospective per discharge rate for the subsequent year will

exceed 105 percent of the rate that would have otherwise been paid to the hospital;

(v) in addition to requirements Items (i) through (iv) above, appeals for rate adjustment will not be considered if cost changes are due to changes in hospital occupancy rate, collective bargaining actions, changes in hospital ownership or affiliation, or changes in levels of rates of increases of incurred cost items which were included in the base rate;

(b) the appeal must provide a specific recommendation(s) regarding the magnitude of alterations in the appellant's prospective rate per discharge and peer group reassignment, as applicable; in making its decision on any appeal, the department shall be limited to the following options:

(i) reject the appeal on the basis of a failure of the appellant to demonstrate necessary conditions and documentation for an appeal as specified in Subparagraph (a) of Paragraph (1) of Subsection D of 8.311.3.12 NMAC above; or

(ii) accept all of the specific recommendations, as stated in the appeal, in their entirety; or

(iii) adopt modified versions of the recommendations as stated in the appeal; or

(iv) reject all of the recommendations in the appeal;

(c) hospitals are limited to one appeal per year, which must be filed in writing with the [~~medical assistance division~~] MAD director by a duly authorized officer of the hospital no later than July 1 of each year; within 15 calendar days of the filing date, the department shall offer the appellant the opportunity for hearing of the appeal; if such a hearing is requested, it shall occur within 30 calendar days of the filing date; the department shall notify the appellant of the decision of the appeal in writing no later than September 15 of the year in which the appeal is filed.

E. **Retroactive settlement:**

(1) Retroactive settlement may occur in those cases in which no audited cost reports were available at the time of rate setting and an interim rate was used. Retroactive settlement will only occur in those cases where adjustments to interim rates are required. For year [~~1~~] one, the department's audit agent will determine the difference between payments to the hospital under the interim operating cost per discharge rate and what these payments would have been under the final rate. The audit agent will report the amount of overpayment or underpayment for each facility within 90 calendar days of the effective date of the final rate. Retroactive settlements will be based on actual claims paid while the interim rate was in effect.

(2) **Underpayments:** In the event that the interim rate for year [~~1~~] one is less than the final rate, the department will include the amount of underpayment in a subsequent payment to the facility within 30 calendar days of notification of underpayment.

(3) **Overpayments:** In the event that the interim rate exceeds the final rate, the following procedure will be implemented: the facility will have 30 calendar days from the date of notification of overpayment to submit the amount owed to the department in full. If the amount is not submitted on a timely basis, the department will begin withholding from future payments until the overpayment is satisfied in full.

(4) Retroactive settlements for excludable costs will be handled in the same manner as described above.

F. **Special prospective payment provisions:**

(1) **Outlier cases:**

(a) Effective for discharges occurring on or after April 1, 1992, outlier cases are defined as those cases with medically necessary services exceeding $100,000 in billed charges, or those with medically necessary lengths of stay of 75 calendar days or more, when such services are provided to eligible children up to age six in disproportionate share hospitals, and to eligible infants under age one in all hospitals. These cases will be removed from the DRG payment system and paid at an amount equal to 90[%] percent of the hospital's standardized cost. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio as calculated from the hospital's most recent cost report.

(b) Utilization review will be performed on all outlier cases to determine the medical necessity of services rendered. Should this review determine non-medical necessity for all or part of the services, these services will be deducted from the billed amount prior to payment.

(2) **Payment for transfer cases:**

(a) All cases transferred from one acute care hospital to another will be monitored under a utilization review policy to ensure that the department does not pay for inappropriate transfers.

(b) The following methodology will be used to reimburse the transferring and discharging hospitals for appropriate transfers if both hospitals and any hospital units involved are included in the PPS.

(i) A hospital inpatient shall be considered "transferred" when [~~he or she~~] an eligible recipient has been moved from one DRG acute inpatient facility to another DRG acute inpatient facility. Movement of [~~a patient~~] an eligible recipient from one unit to another unit within the same hospital shall not constitute a transfer, unless the [~~patient~~] eligible recipient is being moved to a PPS exempt unit within the hospital.

(ii) The transferring hospital will be paid the lesser of standardized costs or the appropriate DRG payment amount. Should the stay in the transferring hospital qualify for an outlier payment, then the case will be paid as an outlier as described in Subsection F of 8.311.3.12 NMAC [~~of this part~~]. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio.

(iii) The receiving hospital which ultimately discharges the [~~patient~~] eligible recipient will receive the full DRG payment amount, or, if applicable, any outlier payments associated with the case. All other hospitals which admitted and subsequently transferred the [~~patient~~] eligible recipient to another acute care hospital during a single spell of illness shall be considered transferring hospitals.

(c) If the transferring or discharge hospital or unit is exempt from the PPS, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or unit.

(3) **Payment for readmissions:**

(a) Readmissions that occur within 24 hours of the previous discharge of an eligible recipient with the same or related diagnosis related group (DRG) will be considered part of the prior admission and not paid separately when the admissions are to the same hospital. When the second admission is to a different hospital, the claims may be reviewed to determine if the initial claim should be considered as a transfer.

(b) Readmissions occurring within 15 calendar days of prior acute care admission for a related condition [~~will~~] may be reviewed to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the department.

(4) **Payment for inappropriate brief admissions:** Hospital stays of up to two calendar days in length [~~will~~] may be reviewed for medical necessity and appropriateness of care. (Discharges involving eligible recipient healthy mothers and healthy newborns are excluded from this review [~~requirement~~] provision.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient discharge will be denied. If the inpatient claim is denied, the hospital is permitted to resubmit an outpatient claim for the services rendered. Such review may be further focused to exempt certain cases at the sole discretion of the department.

(5) **Payment for non-medically**

warranted days:

(a) Reimbursement for [~~hospital patients~~] eligible recipients admitted to a hospital receiving services at an inappropriate level of care will be made at rates reflecting the level of care actually received. The number of days covered by the [~~medicaid~~] MAD program is determined based only upon medical necessity for an acute level of hospital care.

(b) When it is determined that an [~~individual~~] eligible recipient no longer requires acute-level care but does require a lower level of institutional care, and when placement in such care cannot be located, [~~the~~] a DRG hospital will be reimbursed for "awaiting placement" days. Reimbursement will be made at the weighted average rate paid by the department in the preceding calendar year for the level of care needed. There is no limit on the number of covered "awaiting placement" days as long as those days are medically necessary. However, the hospital is encouraged to make every effort to secure appropriate placement for the [~~individual~~] eligible recipient as soon as possible. During "awaiting placement" days, no ancillary services will be paid, but medically necessary physician visits will be reimbursed.

(6) **Sole community hospital payment adjustment:** Effective for the quarter beginning July 1, 1993, in-state care hospitals that qualify as sole community hospitals are entitled to receive a sole community hospital payment adjustment in accordance with the provisions specified below:

(a) To qualify for a sole community hospital payment adjustment, an acute care hospital must meet the medicare classification criteria for a sole community hospital as set forth at 42 CFR 412.92. The hospital must qualify for a sole community hospital designation in the month prior to the effective date for the sole community adjustment. If a hospital already has a sole community hospital designation from medicare this designation will be accepted by the [~~medicaid~~] MAD program. If for some reason, the hospital elected not to apply for sole community hospital designation under medicare but [~~wished~~] wishes to apply for [~~medicaid~~] MAD purposes only, such application must be made directly to the [~~medicaid~~] MAD program. The [~~medicaid~~] MAD program will review the application in accordance with the criteria contained at 42 CFR 412.92.

(b) For an in-state acute care hospital that qualifies as a sole community hospital in accordance with [~~paragraph (6)(a)~~] Subparagraph (a) of Paragraph (6) above, the department will make a quarterly sole community hospital payment at the end of each quarter. For the initial payment year (July 1, 1993, through June 30, 1994), the payment is the amount specified under [~~paragraph (6)(c)~~] Subparagraph (c) of Paragraph (6) below. For subsequent years, the amount will be the amount calculated under [~~paragraph (6)(d) through (6)(f)~~] Subparagraphs (c) through (f) of Paragraph (6) below.

(c) For the initial payment year, the sole community hospital payment amount will be equal to the amount the hospital received from county government, either through the County Indigent Claims Act or by mill levy revenues dedicated to supporting the hospital's operating expenses, for calendar year 1992 (the base year) plus the inflation factor described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC [~~of this part~~]. Verification of the base year amount will be made from the official report of expenditures by each county. [~~Hospital~~] A hospital will have the opportunity to challenge the amount by filing an appeal with the department within 30 calendar days from the date they receive notice from the state of their sole community payment amount. If the hospital qualifies for the sole community designation at a date later than the effective date of the plan amendment, [~~the medicaid~~] MAD program will prorate the sole community payment adjustment for the first quarter from the date of qualification to the end of that quarter.

(d) For each subsequent plan year, the sole community hospital is required to submit to the department, no later than January 15 for the subsequent state fiscal year, a sole community hospital payment request. If the hospital cannot meet the January 15 deadline, the hospital may submit a written request for up to 30-calendar day extension. Such requests must be received prior to the January 15 deadline.

(e) The sole community provider payment request must be reviewed and approved by the county government in which the hospital is located. In order for the request to be valid, the county government's approval must be submitted with the hospital's request. If the hospital does not submit a valid request within the time frame identified above, it will not be eligible for a sole community provider adjustment for that year regardless of the hospital's status as a sole community hospital.

(f) For years subsequent to the initial payment year, the sole community hospital payment adjustment will be the [~~lessor~~] lesser of the amount paid by the department for the previous year trended forward. The department will use the market basket forecast published periodically in the CMS regional medical services letter, or an amount mutually agreed upon by the hospital and the county government.

(g) The department will calculate the medicare payment limit (specified at 42 CFR 447) annually. If the upper limit has not been exceeded, additional payments will be distributed by the department. Should the amounts requested from the hospitals exceed the amount available under the upper limit, the amounts will be prorated and distributed based on the amount of the request received by the department.

(7) **State-operated teaching hospital adjustment:** Teaching hospitals (as defined in section 4.19-(A)(III)(F)(8)(a) of the state plan operated by the state of New Mexico or an agency thereof) shall qualify for an inpatient state operated teaching hospital rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's medicare-related upper payment limit (specified at 42 CFR 447.272). The department will calculate the medicare upper payment limit for state-operated teaching hospitals annually. If the upper payment limit has not been exceeded, additional payments will be distributed by the department to the state-operated teaching hospital. The adjustment shall be calculated as follows:

(a) Each federal fiscal year, the department shall determine each state-operated teaching hospital's medicare per discharge rate and [~~medicaid~~] MAD per discharge rate. The medicare [~~and/or medicaid~~] or MAD discharge rate will be adjusted to reflect any acuity differences that exist between the medicare and [~~medicaid patients~~] eligible recipients served. Acuity differences will be determined from the medicare and [~~medicaid~~] MAD case-mix indices (CMI) for [~~medicaid~~] MAD discharges at the hospital using medicare and [~~medicaid~~] MAD DRG weights in effect at the time (using data from the most recent state fiscal year for which complete data is available).

(b) The [~~medicaid~~] MAD per discharge rate shall be subtracted from the medicare per discharge rate.

(c) The difference shall be multiplied by the number of [~~medicaid~~] MAD discharges at the hospital for the most recent state fiscal year. The result shall be the amount of the state-operated teaching hospital adjustment for the current federal fiscal year.

(d) For federal fiscal year 2000, and subsequent federal fiscal years, payment shall be made on an annual basis before the end of the federal fiscal year.

(e) In the event that the state-operated teaching adjustment amount exceeds the medicare-related upper payment limit for that year, the state-operated teaching hospital adjustment will be revised by the difference.

(8) **Indirect medical education (IME) adjustment:** Effective August 1, 1992, each acute care hospital that qualifies as a teaching hospital will receive an

indirect medical education (IME) payment adjustment, which covers the increase operating or patient care costs that are associated with approved intern and resident programs.

(a) In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

(i) be licensed by the state of New Mexico; and

(ii) be reimbursed on a DRG basis under the plan; and

(iii) have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(b) Determination of a hospital's eligibility for an IME adjustment will be done annually by the department, as of the first day of the provider's fiscal year. If a hospital meets the qualification for an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualification were met.

(c) The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

$1.89*((1+R)^{.405}-1)$

where R equals the number of approved full-time equivalent residents divided by the number of available beds (excluding nursery and neonatal bassinets). Full-time equivalent residents are counted in accordance with 42 CFR 412.105(f). For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for [~~medicaid~~] MAD managed care enrollees if those persons had not been enrolled in managed care.

(d) Quarterly IME payments will be made to qualifying hospital at the end of each quarter. Prior to the end of each quarter, the provider will submit to the department's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the [~~medicaid~~] MAD DRG amount. After review and adjustment, if necessary, the audit agent will notify the department of the amount due to/from the provider for the application quarter. Final settlement of the IME adjustment amount will be made through the cost report; that is, the number of beds, residents, and DRG amounts used in the quarterly calculation will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

(9) **Payment for direct graduate medical education (GME):** Effective for services provided on or after July 1, 1998, payment to hospitals for GME expense is made on a prospective basis as described in this section. Payments will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital during the preceding year, and subject to an upper limit on total payments.

(a) To be counted for [~~medicaid~~] MAD reimbursement, a resident must be participating in an approved residency program, as defined by medicare in 42 CFR 413.86. With regard to categorizing residents, as described in [~~paragraph (9)(b)~~] Subparagraph (b) of Paragraph (9) below, the manner of counting and weighting resident FTEs will be the same as is used by medicare in 42 CFR 413.86. Resident FTEs whose costs will be reimbursed by the department as a medical expense to a federally qualified health center are not eligible for reimbursement under this section. To qualify for [~~medicaid~~] MAD GME payments, a hospital must be licensed by the state of New Mexico, be currently enrolled as a [~~medicaid~~] MAD provider, and must have achieved a [~~medicaid~~] MAD inpatient utilization rate of 5[~~%~~] percent or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the [~~medicaid~~] MAD inpatient utilization rate will be calculated as the ratio of New Mexico [~~medicaid~~] MAD eligible days, including inpatient days paid under [~~medicaid~~] MAD managed care arrangements, to total inpatient hospital days.

(b) Approved resident FTEs are categorized as follows for [~~medicaid~~] MAD GME payment:

(i) **Primary care/ obstetrics resident.** Primary care is defined per 42 CFR 413.86(b).

(ii) **Rural health resident.** A resident is defined as participating in a designated rural health residency program. Residents enrolled in a designated rural health residency program will be counted as a rural health resident FTE for the entire duration of their residency, including those portions of their residency which may be served in a non-rural hospital or clinic. Should any resident meet the criteria for both rural health and primary care in this section, this resident will be counted as a rural health resident.

(iii) **Other approved resident.** Any resident not meeting the criteria in [~~subparagraphs~~] Items (i) or (ii), above.

(c) **[~~Medicaid~~] MAD GME payment amount per resident FTE:**

(i) The annual [~~medicaid~~] MAD payment amount per resident FTE for state fiscal year 1999 is as follows:

Primary care/obstetrics resident: $22,000

Rural health resident: $25,000

Other resident: $21,000

(ii) The per resident amounts specified in Item (i) of Subparagraph (c) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC will be inflated for state fiscal years beginning on or after July 1, 1999 using the annual inflation update factor described in Item (ii) of Subparagraph (d) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC.

(d) **Annual inflation update factor:**

(i) Effective for state fiscal years 2000 and beyond, the department has updated the per resident GME amounts and the upper limit on GME payments for inflation, using the market basket forecast published in the CMS Dallas regional medical services letter issued for the quarter ending in March 1999 to determine the GME rates for state fiscal year 2000 (July 1, 1999 - June 30, 2000).

(ii) The department will use the market basket forecast shown for PPS hospitals that is applicable to the period during which the rates will be in effect. [~~The medical assistance division~~] MAD will determine the percentage of funds available for GME payments to eligible hospitals.

(e) **Annual upper limits on GME payments:**

(i) Total annual [~~medicaid~~] MAD GME payments will be limited to $5,800,000 for state fiscal year 1999. This amount will be updated for inflation, beginning with state fiscal year 2000, in accordance with Subparagraph (d) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC.

(ii) Total annual GME payments for residents in Category B.3, "Other," will be limited to the following percentages of the $5,800,000 total annual limit (as updated for inflation in accordance with Subparagraph (d) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC).

state fiscal year 1999 58.3[~~%~~] percent

state fiscal year 2000 56.8[~~%~~] percent

state fiscal year 2001 53.3[~~%~~] percent

state fiscal year 2002 50.7[~~%~~] percent

state fiscal year 2003 48.0[~~%~~] percent

state fiscal year 2004 45.5[~~%~~] percent

state fiscal year 2005 43.0[~~%~~] percent

state fiscal year 2006 40.4[~~%~~] percent

(f) **Reporting and payment schedule:**

(i) Hospitals will count the number of residents working according to the specification in this part during each fiscal year (July 1 through June 30) and will report this information to the department by December 31. Counts will represent the weighted average number of residents who worked in the hospitals during the specified 12-month period. Hospitals may also add to this count any FTEs associated with newly approved residency programs that will be implemented on or before the start of the prospective GME payment year, to the extent that these FTEs are not already reflected in the weighted average counts of the preceding year. To illustrate, resident FTE amounts would be counted from 07/01/96 - 06/30/97 for the payment year 07/01/98 - 06/30/99. The department may require hospitals to provide documentation necessary to support the summary counts provided.

(ii) The department will establish the amount payable to each hospital for the prospective payment period that will begin each July 1. Should total payments as initially calculated exceed either of the limitations in Subsection D of 8.311.3.12 NMAC, the amount payable to each will be proportionately reduced.

(iii) The annual amount payable to each hospital is divided into four equal payments. These payments will be made by the department on or about the start of each prospective payment quarter.

(iv) Should a facility not report timely with the accurate resident information as required in Item (i) of Subparagraph (f) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remain available under the upper limits described in Subsection D of 8.311.3.12 NMAC, after prospective payment amounts to timely filing facilities have been established.

[2-1-95, 10-31-97, 6-30-98, 9-1-98, 1-1-99, 8.311.3.12 NMAC - Rn, 8 NMAC 4.MAD.721.D.III & A, 1-1-01; A, 10-1-02; A, 7-1-04; A, 4-1-11]

8.311.3.13

DISPROPORTIONATE SHARE HOSPITALS: To take into account the situation of hospitals serving a disproportionate number of low-income patients with special needs, a payment will be made to qualifying hospitals.

A. **Criteria for deeming hospitals eligible for a disproportionate share payment:**

(1) Determination of each hospital's eligibility for a disproportionate share payment for the [~~medicaid~~] MAD inpatient utilization rate as listed below, will be done annually by the department's audit agent, based on the hospital's most recently filed cost report. Hospitals which believe they qualify under the low income utilization rate must submit documentation justifying their qualification. This documentation should be submitted to the department by March 31 of each year.

(2) In the case of a DRG hospital with a PPS exempt specialty unit, data from the entire facility will be considered to determine DSH status.

(3) The following criteria must be met before a hospital is deemed to be eligible:

(a) Minimum criteria: The hospital must have:

(i) a [~~medicaid~~] MAD inpatient utilization rate greater than the mean [~~medicaid~~] MAD inpatient utilization rate for hospitals receiving [~~medicaid~~] MAD payments in the state; or

(ii) a low-income utilization rate exceeding 25 percent; [~~(Refer to 8.311.3.13.A.(3)(b) NMAC~~] (refer to Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC for definitions of these criteria).

(iii) the hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to [~~individuals~~] eligible recipients entitled to such services under [~~medicaid~~] MAD; in the case of a hospital located in a rural area (defined as an area outside of a metropolitan statistical area (MSA), as defined by the U.S. executive office of management and budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures;

(iv) [~~8.311.3.13.A.(3)(iii) NMAC~~] Item (iii) of Subparagraph (a) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC does not apply to a hospital which meets the following criteria: the inpatients are predominantly individuals under 18 years of age; or the hospital did not offer non-emergency obstetric services as of December 22, 1987;

(v) the hospital must have, at a minimum, a [~~medicaid~~] MAD inpatient utilization rate (MUR) of one percent.

(b) **Definitions of criteria:**

(i) [~~Medicaid~~] MAD inpatient utilization: For a hospital, the total number of its [~~medicaid~~] MAD inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days in the same period. These include both [~~medicaid~~] MAD managed care and non-managed care [~~medicaid~~] MAD inpatient days.

(ii) Low-income utilization rate: For a hospital, the sum (expressed as a percentage) of the following fractions: The sum of total [~~medicaid~~] MAD inpatient and outpatient net revenues (this includes [~~medicaid~~] MAD managed care and non-managed care revenues) paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of net revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period; and the total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the amount of the cash subsidies received directly from the state and local governments in that period reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. If this number is zero or less than zero, then it is assumed to be zero. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved [~~medicaid~~] MAD state plan), that is, reductions in charges given to other third-party payers, such as HMOs, medicare, or Blue Cross.

(iii) The medicaid utilization rate (MUR) is computed as follows:

MUR % = 100 x M/T

M = hospital's number of inpatient days attributable to [~~patients who for these days were eligible for medical assistance~~] eligible recipients under the MAD state plan. These include [~~medicaid~~] MAD managed care and non-managed care days.

T = hospital's total inpatient days

(iv) Newborn days, days in specialized wards, and administratively necessary days are included in this calculation. Additionally, days attributable to individuals eligible for medicaid in another state are included. [~~Medicaid~~] MAD inpatient days includes both [~~medicaid~~] MAD managed care and non-managed care patient days.

(v) The numerator (M) does not include days attributable to [~~medicaid patients~~] recipients 21 or older in institutions for mental disease (IMD) as these patients are not eligible for [~~medicaid~~] MAD coverage in IMDs under the New Mexico state plan and cannot be considered a [~~medicaid~~] MAD day.

B. **Inpatient disproportionate share pools:** Section 1923 of the Social Security Act allows qualifying hospitals to receive a

disproportionate share payment, in addition to their allowable regular claims payments and any other payments to which they are entitled. This determination is performed annually as described in [~~8.311.3.13.A NMAC~~] Subsection A of 8.311.3.13 NMAC. Qualifying hospitals will be classified into one of [3] three disproportionate share hospital pools: Teaching PPS hospitals, non-teaching PPS hospitals, and PPS-exempt (TEFRA) hospitals. Hospitals may also qualify for a payment from a [~~4th~~] fourth pool: reserve pool, as explained in this [~~8.311.3.13.C. NMAC~~] Subsection C of 8.311.3.13 NMAC below.

(1) To qualify as a teaching hospital and be eligible for the teaching hospital DSH payment, the hospital must:

(a) be licensed by the state of New Mexico; and

(b) reimbursed, or be eligible to be reimbursed, under the DRG basis under the plan; and

(c) have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(2) A non-teaching PPS (DRG) hospital qualifies if it is an in-state acute care hospital reimbursed by or eligible to be reimbursed by prospective payment methodology.

(3) A PPS-exempt hospital (TEFRA) such as rehabilitation hospitals, children's hospitals, or free-standing psychiatric hospitals, qualify if it is reimbursed by or eligible to be reimbursed by TEFRA (Tax Equity and Finance Reduction Act) methodology as described in 8.311.3.11 NMAC [~~of this policy~~].

(4) The reserve pool is to compensate DSH qualifying hospitals which have had a disproportionate shift in the delivery of services between low-income and [~~medicaid~~] MAD-covered inpatient days in any given quarter. A hospital will qualify for payment from the reserve pool if its charity ratio, as described in [~~8.311.3.13.A.(3)(b)(ii) NMAC~~] Item (ii) pf Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC, exceeds 20 percent. A qualifying hospital may receive a payment from the reserve pool in addition to its payment from one of the three other pools.

C. **Disproportionate share hospital payments:**

(1) The DSH funds allocated to each pool are paid to qualifying hospitals based on the number of [~~medicaid~~] MAD discharges. These include both [~~medicaid~~] MAD managed care and non-managed care discharges. A discharge occurs when a patient dies in the hospital, is formally released from the hospital, or is transferred to another hospital or nursing home.

(2) Payments are made quarterly, with the annual amount for the pool divided into four parts, and each part distributed after the end of each quarter based on [~~medicaid~~] MAD discharges during that quarter. The quarterly payment to each hospital qualifying for DSH pools [~~1, 2, or 3~~] one, two, or three will be computed by dividing the number of [~~medicaid~~] MAD discharges for that hospital by the total number of [~~medicaid~~] MAD discharges from all hospitals qualifying for that DSH pool and then multiplying this pro-rata share by the quarterly allocation for the respective pool. This amount cannot exceed the OBRA 93 DSH limit, which is described in [~~parts 8.311.3.13.E. NMAC and 8.311.3.13.F NMAC~~] Subsections E and F of 8.311.3.13 NMAC.

(3) [~~The medical assistance division~~] MAD will review the allocation of DSH funds prior to the start of each state fiscal year and may re-allocate funds between pools at that time in consideration of shifts in the hospital utilization of [~~medicaid~~] MAD and low-income/indigent care patients.

(4) The percentages allocated to each pool for state fiscal year 98 are as listed below. The total allocations shall be adjusted in subsequent state fiscal years based on the medicare prospective payment update factor (MPPUF) [~~and/or~~] or the DSH budget as defined by [~~HSD~~] the department. The base year DSH budget for state fiscal year 98 is $22,000,000.00.

(a) The teaching PPS hospital DSH pool is 56[%] percent of the overall DSH budget, as defined by HSD.

(b) The non-teaching PPS (DRG) hospital DSH pool is 22.5[%] percent of the overall DSH budget, as defined by HSD.

(c) The PPS-exempt hospital (TEFRA) DSH pool is 1.5[%] percent of the overall DSH budget, as defined by HSD.

(d) The reserve DSH pool is 20[%] percent of the overall DSH budget, as defined by HSD. Quarterly payments may be made directly from the reserve pool to hospitals qualifying for any of the other three DSH pools at the rate of N dollars per [~~medicaid~~] MAD discharge, where N is equal to the fraction described in [~~8.311.3.13.A.(3)(b)(ii) NMAC of this part~~] Item (ii) of Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC minus 20[%] percent, multiplied by $1,750.

D. **Request for DSH payment procedures:** Hospitals must submit to the department the number of [~~medicaid~~] MAD discharges (both managed care and fee for service discharges), which they have incurred 30 calendar days after the end of each quarter. The department will review the hospital's documentation supporting their discharge information. Any requests received later than 60 calendar days from the end of the quarter will be denied as untimely.

E. **DSH limits:**

(1) Pursuant to section 1923 (g) of the Social Security Act, a limit is placed on the payment adjustment for any hospital. A hospital's payment adjustment determined in [~~subsections 8.311.3.13.B NMAC through 8.311.3.13.D. NMAC~~] Subsections B through D of 8.311.3.13 NMAC shall not exceed that hospital's hospital-specific DSH limit, as determined under [~~8.311.3.13.E. NMAC~~] Subsection E of 8.311.3.13 NMAC. This limit is calculated as follows:

DSH limit = M + U

M = Cost of services to [~~medicaid patients~~] eligible recipients, less the amount paid by the [~~medicaid~~] MAD program under the non-DSH payment provisions of this plan.

U = Cost of services to uninsured patients, less any cash payments made by them.

(2) The cost of services will include both inpatient and outpatient costs for purposes of calculating the limit. The "costs of services" [~~is~~] are defined as those costs determined allowable under this plan. "Uninsured patients" are defined as those patients who do not possess health insurance or do not have a source of third party payment for services provided, including individuals who do not possess health insurance which would apply to the service for which the individual sought treatment. Payments made to a hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

F. **Limitations in New Mexico DSH allotment:** If the DSH payment amounts as described in [~~parts 8.311.3.13.C. NMAC through 8.311.3.13.E. NMAC~~] Subsections C through E of 8.311.3.13 NMAC above, exceed in any given year, the federal determined DSH allotment for New Mexico, the DSH allocations by pool will be reduced proportionately to a level in compliance with the New Mexico DSH allotment.

[2-1-95, 1-31-96, 7-31-97; 8.311.3.13 NMAC - Rn, 8 NMAC 4.MAD.721.D.IV, 1-1-01; A, 9-1-01; A, 4-1-11]

8.311.3.14 DETERMINATION OF ACTUAL, ALLOWABLE, AND REASONABLE COSTS

A. **Adequate cost data**

(1) All hospitals must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The hospital will submit a cost report each year. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(2) The cost finding method

to be used by hospitals will be the step-down method. This method recognizes that services rendered by certain non-revenue-producing departments or centers are utilized by certain other non-revenue-producing centers. All costs of non-revenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue-producing center serving the greatest number of other centers while receiving benefits from the least number of centers is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greatest amount of expense will be allocated first.

B. **Reporting year:** For the purpose of determining payment rates, the reporting year is the hospital's fiscal year.

C. **Cost reporting:** At the end of each of its fiscal years, the hospital will provide to the department or [~~it~~] its audit agent an itemized list of allowable costs (financial and statistical report) on the New Mexico [~~title XIX~~] MAD cost reporting form. The cost report must be submitted within 90 calendar days after the close of the hospital's fiscal year. Failure to file a report within the 90 calendar day limit, unless an extension is granted, will result in suspension of [~~title XIX~~] MAD payments, until such time as the report is received.

D. **Retention of records:**

(1) Each hospital will maintain financial and statistical records of the period covered by such cost report for a period of not less than four years following the date of submittal of the New Mexico [~~title XIX~~] MAD cost report to the department. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider will make such records available upon demand to representatives of the department, the state of New Mexico audit agent, or the United States department of health and human services.

(2) The department or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such reports.

E. **Audits:**

(1) **Desk audit:** Each cost report submitted will be subjected to a comprehensive desk audit by the state's audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the department.

(2) **Field audit:** Field audits will be performed on all facilities [~~ad~~] and per the auditing schedule established by medicare. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost report [~~are~~] is accurate, complete, and reasonable. The field audits are conducted in accordance with generally accepted auditing standards. Field audits are of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expense attributable to such proper items of cost was accurately determined and reasonable. After each field audit is performed, the audit agent will submit a complete report of the audit to the department. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate, and reasonable. These audit reports will be retained by the department for a period of not less than three years from the date of final settlement of such reports. Audits will be performed in accordance with applicable federal regulations.

F. **Overpayments:** All overpayments found in audits will be accounted for on the [~~HCFA-64~~] CMS-64 report in accordance with 42 CFR 433.300 through 42 CFR 433.322.

G. **Allowable and non-allowable costs:** Allowable costs, non-allowable costs, and reasonableness of costs will be determined as on the basis of the [~~HIM-15~~] medicare health insurance manual (HIM-15).

[2-1-95; 8.311.3.14 NMAC - Rn, 8 NMAC 4.MAD.721.D.V, 1-1-01; A, 4-1-11]

8.311.3.15 PUBLIC DISCLOSURE OF COST REPORTS

A. As required by law, cost reports submitted by participating providers as a basis for reimbursement are available to the public upon receipt of a written request to the medical assistance program audit agent. Disclosure information is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The provider whose report has been requested will be notified by the [~~medical assistance program~~] MAD audit agent that its cost report has been requested, by whom the request was made, and that the provider shall have 10 calendar days in which to comment to the requestor before the cost report is released.

D. The cost for copying will be charged to the requestor.

[2-1-95; 8.311.3.15 NMAC - Rn, 8 NMAC 4.MAD.721.D.VI, 1-1-01; A, 4-1-11]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Explanatory paragraph: This is an amendment to 8.314.5 NMAC, Section 13, which will be effective April 1, 2011. The Medical Assistance Division is amending Subsection C and Paragraph (1) of Subsection G., striking the specific language that respite care services provided to individuals in family living may not be billed for the same time period as family living.

8.314.5.13 COVERED WAIVER SERVICES: This medicaid waiver covers the following services for a specified and limited number of waiver recipients as a cost effective alternative to institutionalization in an ICF-MR. The program is limited to the number of federally authorized unduplicated recipient (UDR) positions and program funding.

C. **Respite care services:** Respite is a flexible family support service. The primary purpose of respite is to provide support to the individual and give the primary, unpaid caregiver time away from their duties. The respite care provider assists the individual in activities of daily living to promote the individual's health and safety, as well as maintain a clean and safe environment. Respite will be scheduled as determined by the primary caregiver. Respite services can be included in the ISP with personal support, adult day habilitation, individual, group and customized supported employments, and community access as long as the services are not provided for the same hours of the same day with the exception of therapies and case management. Respite services cannot be provided for individuals receiving supported or independent living services. [~~Respite may be provided to individuals in family living, but the service may not be billed for the same time period as family living.~~] Respite may be provided in the client's own home, in a provider's home or in a community setting of the family's choice. Respite services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

G. **Community living services:** Community living services are intended to provide persons with the assistance and support needed in a home environment in order to increase or maintain an individual's capacity for independent functioning, self-determination, interdependence, productivity and integration in the community. Community

living services are only available for individuals for whom no other residential or support options are clinically appropriate to meet the needs of the individual. Community living services must be justified by the IDT as the only service which can meet the needs of the individual.

(1) This service includes personal support, nutritional counseling and nursing supports and, therefore, personal support, nutritional counseling and private duty nursing services may not be included in an ISP for an individual receiving community living services. Respite services cannot be provided to individuals receiving supported or independent living services. [~~Respite services may be provided to individuals in family living, but the service may not be billed for the same time period as family living.~~] Room and board costs are reimbursed through the individual's SSI or other personal accounts and cannot be paid through the waiver service.

[8.314.5.13 NMAC - Rp, 8.314.5.13 NMAC, 3-1-07; A, 4-1-11]

End of Adopted Rules Section

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Other Material Related to Administrative Law

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD
NOTICE OF STATE IMPLEMENTATION PLAN HEARING

The New Mexico Environmental Improvement Board ("Board") will hold a public hearing on June 2, 3 or 4, 2011 in Farmington, New Mexico at San Juan College, 4601 College Blvd. The hearing will commence immediately following the hearing in EIB No. 11-01 (R), scheduled for June 2 - 4 (as necessary), 2011 at the same location. The New Mexico Environment Department ("NMED") is proposing to adopt revisions to the New Mexico State Implementation Plan to satisfy the requirements of Clean Air Act Section 110(a)(2)(D)(i)(II) with respect to visibility for the 8-hour ozone and particulate matter under 2.5 microns in diameter (PM 2.5) National Ambient Air Quality Standards promulgated in July 1997.

The proponent of this regulatory adoption and revision is the New Mexico Environment Department ("NMED").

The purpose of the public hearing is to consider and take possible action on a petition from NMED regarding revisions to New Mexico's State Implementation Plan (SIP). The "Good Neighbor" provision of the Clean Air Act (CAA) at Section 110(a)(2)(D)(i) requires that each state implementation plan (SIP) submitted to EPA must address emissions from within the state that affect other states through interstate transport. The NMED's Best Available Retrofit Technology (BART) determination for nitrogen dioxide for the San Juan Generating Station (SJGS) calls for an emission rate of 0.23 pounds per million British thermal units (lbs/mmBtu). In order to address the separate requirement to satisfy Section 110(a)(2)(D) for sulfur dioxide, SJGS has agreed to a permit modification to implement a limit of 0.15 lbs/mmBtu for sulfur dioxide. These nitrogen dioxide and sulfur dioxide emission limits ensures that New Mexico will meet or exceed the expectations of neighboring states for visibility.

The proposed revised plan may be reviewed during regular business hours at the NMED Air Quality Bureau office, 1301 Siler Road, Building B, Santa Fe, New Mexico. The full text of NMED's proposed State Implementation Plan is available on NMED's web site at www.nmenv.state.nm.us, or by contacting Rita Bates at (505) 476-4304 or by email at rita.bates@state.nm.us.

The hearing will be conducted in accordance with 20.1.1 NMAC (Rulemaking Procedures – Environmental Improvement Board), the Environmental Improvement Act, Section 74-1-9 NMSA 1978, the Air Quality Control Act, Section 74-2-6 NMSA 1978, and other applicable procedures.

All interested persons will be given reasonable opportunity at the hearing to submit relevant evidence, data, views and arguments, orally or in writing, to introduce exhibits, and to examine witnesses. Persons wishing to present technical testimony must file with the Board a written notice of intent to do so. The notice of intent shall:

(1) identify the person for whom the witness(es) will testify;
(2) identify each technical witness that the person intends to present and state the qualifications of the witness, including a description of their education and work background;
(3) include a copy of the direct testimony in narrative form of each technical witness and state the anticipated duration of the testimony of that witness;
(4) attach each exhibit anticipated to be offered by that person at the hearing; and
(5) attach the text of any recommended modifications to the proposed new and revised regulations.

Notices of intent for the hearing must be received in the Office of the Board not later than 5:00 pm on May 17, 2011, and should reference the docket number, EIB 11-02 (R), and the date of the hearing. Notices of intent to present technical testimony should be submitted to:

Felicia Orth, Acting Board Administrator
Office of the Environmental Improvement Board
Harold Runnels Building
1190 St. Francis Dr., Room 2150-N
Santa Fe, NM 87502
Phone: (505) 827-0339, Fax (505) 827-2836

Any member of the general public may testify at the hearing. No prior notification is required to present non-technical testimony at the hearing. Any such member may also offer exhibits in connection with his testimony, so long as the exhibit is not unduly repetitious of the testimony.

A member of the general public who wishes to submit a written statement for the record, in lieu of providing oral testimony at the hearing, shall file the written statement prior to the hearing, or submit it at the hearing.

Persons having a disability and needing help in being a part of this hearing process should contact Judy Bentley by May 17, 2011 at the NMED, Personnel Services Bureau, P.O. Box 5469, 1190 St. Francis Drive, Santa Fe, New Mexico, 87502-5469, telephone 505-827-9872. TDY users please access her number via the New Mexico Relay Network at 1-800-659-8331.

The Board may make a decision on the proposed revised state implementation plan at the conclusion of the hearing, or the Board may convene a meeting at a later date to consider action on the proposal.

End of Other Related Material Section

Submittal Deadlines and Publication Dates
2011

Volume XXII	Submittal Deadline	Publication Date
Issue Number 1	January 4	January 14
Issue Number 2	January 18	January 31
Issue Number 3	February 1	February 14
Issue Number 4	February 15	February 28
Issue Number 5	March 1	March 15
Issue Number 6	March 16	March 31
Issue Number 7	April 1	April 15
Issue Number 8	April 18	April 29
Issue Number 9	May 2	May 16
Issue Number 10	May 17	May 31
Issue Number 11	June 1	June 15
Issue Number 12	June 16	June 30
Issue Number 13	July 1	July 15
Issue Number 14	July 18	July 29
Issue Number 15	August 1	August 15
Issue Number 16	August 16	August 31
Issue Number 17	September 1	September 15
Issue Number 18	September 16	September 30
Issue Number 19	October 3	October 17
Issue Number 20	October 18	October 31
Issue Number 21	November 1	November 15
Issue Number 22	November 16	November 30
Issue Number 23	December 1	December 15
Issue Number 24	December 16	December 30