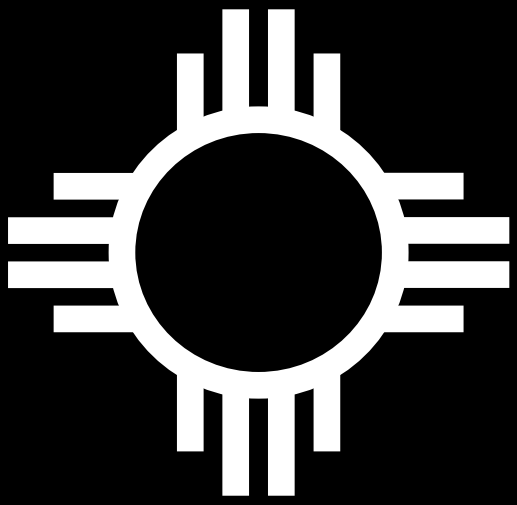
NEW MEXICO REGISTER



Volume XXII
Issue Number 17
September 15, 2011

New Mexico Register

Volume XXII, Issue Number 17
September 15, 2011

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

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

New Mexico Register

Volume XXII, Number 17
September 15, 2011

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Adopted Rules

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A=***Amended***, E=***Emergency***, N=***New***, R=***Repealed***, Rn=***Renumbered***

The ***New Mexico Register*** is available free at http://www.nmcpr.state.nm.us/nmregister

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Notices of Rulemaking and Proposed Rules

NEW MEXICO DEPARTMENT OF AGRICULTURE

Notice of Hearing

New Mexico Department of Agriculture (NMDA) is proposing to pass a new rule:

* Creation of 21.16.7 NMAC, establishing the New Mexico Chile Labeling requirements for New Mexico chile and products offered for sale containing New Mexico chile, under the New Mexico Chile Advertising Act, Chapter 25, Article 11, Sections 1 through 5, New Mexico Statutes Annotated 1978 Compilation.

NMDA is holding two public hearings. The first will be held in Las Cruces, New Mexico, at the NMDA Conference Room, 3190 South Espina Street (Corner of Espina and Gregg), at 1:00 p.m. on Tuesday, October 11, 2011. A second hearing will be held in Albuquerque, New Mexico, at the NMSU Albuquerque Center, 4501 Indian School Road, NE, Suite 100, at 1:00 p.m. on Wednesday, October 19, 2011.

Written statements in support or opposition and signed by the submitting person will be accepted if received prior to 5:00 p.m. on Wednesday, October 19, 2011. Address written statements or inquiries to Joe Gomez at NMDA, Standards and Consumer Services Division, MSC 3170, P.O. Box 30005, Las Cruces, New Mexico 88003-8005 or telephone (575) 646-1616.

A copy of all proposed rules will also be posted on the NMDA website http://nmdaweb.nmsu.edu/.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NOTICE

The New Mexico Human Services Department (HSD) is scheduling a public hearing on Monday, October 17, 2011, at 9:00 a.m. in the South Park Conference Room, 2055 S. Pacheco, Ste. 500-590 in Santa Fe, NM.

The subject of the hearing is Reconsideration of Utilization Review Decisions. The Human Services Department, Medical Assistance Division (HSD/MAD) is proposing to clarify the reconsideration of utilization review process. Specific changes to this proposed rule are:

* Additional language to clarify the reconsideration process and reference other applicable MAD rules;
* Specifying time frames for actions;
* Removal of language regarding "re-reviews" from the rule to implement MAD's intent that the rule is specific for "reconsideration" of a utilization review decision; and
* Additional language clarifying eligible recipient's right to request a provider to pursue reconsideration on his or her behalf.

Interested persons may submit written comments no later than 5:00 p.m., October 17, 2011, to Sidonie Squier, Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

Copies of the Human Services Register and their proposed rules are available for review on our Website at www.hsd.state.nm.us/mad/registers/2011 or by sending a self-addressed stamped envelope to Medical Assistance Division, Benefits Services Bureau, P.O. Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

The New Mexico Human Services Department (HSD) is scheduling one public hearing on October 17, 2011 and two public hearings on October 19, 2011. All three hearings will be held in the ASD conference room, Plaza San Miguel, 729 St. Michael's Drive, Santa Fe.

The first hearing is scheduled for October 17 at 1:30 p.m. The subjects are Hospital Services; Methods and Standards for Establishing Payment Inpatient Hospitals; Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals; and Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals

The Human Services Department, Medical Assistance Division, is proposing changes to 8.311.2 NMAC *Hospital Services*, 8.311.3 NMAC *Methods and Standards for Establishing Payment Inpatient Hospitals*, 8.321.2 NMAC *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals*, and 8.321.5 NMAC *Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals*, by adding language that affects reimbursement rates. Specifically these proposed changes are: Interim reimbursement rates for inpatient specialty hospitals payment are established by MAD to equal or closely approximate the final payment rates that apply under cost settlement TEFRA principles. If they are not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011.Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment.
* levels for services of similar cost, complexity and duration.
* Reimbursement rates for specialty hospitals not subject to cost settlement. If a provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011.
* Establish reimbursement for critical access hospitals under the Outpatient Prospective Payment System (OPPS) will be reimbursed at the rates determined by HSD to equal or closely approximate the final payment rates that apply under the cost settlement TERFA principals. If a provider is not cost settled, the reimbursement rate will be a the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to December 1, 2011.

The changes in the hospitals, methods and standards, inpatient psychiatric hospitals, and outpatient/partial psychiatric hospitals rule are being proposed at this time to assure payments and interim payments to providers are reasonable. An increase or reduction in overall provider payments is not anticipated.

Interested persons may submit written comments no later than 5:00 p.m., October 17, 2011, to Sidonie Squier, Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will

be considered prior to issuance of the final regulation.

The second hearing is scheduled for October 19, 2011 at 9:30 a.m. The Subject is: Provider Hearings

The Human Services Department (the Department), Medical Assistance Division (MAD), is proposing to revise 8.353.2 NMAC *Provider Hearings*. The Department is revising this rule to address specific concerns that have arises since it was last published. Specific changes to this proposed rule are:

* Additional language stating if the New Mexico Office of the Attorney General-Medicaid Fraud Control Unit has directed MAD to withhold payments from a provider, then that provider is not eligible to request an administrative hearing from the Department's Fair Hearings Bureau;
* Additional language clarifying the Department's usage of "good cause" when denying an administrative hearing;
* Language clarifying that administrative hearings will be denied to providers when the sole issue concerns the substance of the rule rather than the application of the rule to the provider;
* Language amending the Department's internal work flow to ensure reasonable timeframes for delivery and receipt of administrative hearing requests are met;
* Language clarifying the rules of summary of evidence, hearing standards, and hearing conduct.

The third hearing is scheduled for October 19, 2011 at 10:30 am. The subject is: Billing for Medicaid Services

The Human Services Department (the Department), Medical Assistance Division (MAD), is proposing amendments to rules 8.302.2 NMAC *Billing for Medicaid Services* to provide information to providers on how to correctly report service units. It is the Department's intention to follow the Centers for Medicare and Medicaid guidelines for reporting service units for reimbursement. Also in this rule, the Department is proposing if an eligible recipient's provider has inappropriately turned that eligible recipient's account over to a collection entity, the provider must now notify the eligible recipient they have directed the collection entity to stop further actions or demands against the eligible recipient. The eligible recipient will now have the information which allows the eligible recipient to verify that his/her credit report has been corrected by the collection entity.

Interested persons may submit written comments no later than 5:00 p.m., October 19, 2011, to Sidonie Squier, Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

Copies of the Human Services Register and their proposed rules are available for review on our Website at www.hsd.state.nm.us/mad/registers/2011 or by sending a self-addressed stamped envelope to Medical Assistance Division, Benefits Services Bureau, P.O. Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO BOARD OF NURSING

Public Rules Hearing

The New Mexico Board of Nursing will hold a Rules Hearing on Friday, October 14. 2011 at 9:00 a.m. The rules hearing will be held at the New Mexico Board of Nursing Conference Room, 6301 Indian School NE, Suite 710, Albuquerque, New Mexico 87110.

The purpose of the rules hearing is to hear public testimony and comments regarding the proposed amendments to the Board's rules and regulations: 16.12 NMAC: Part 1 General Provisions, 16.12 NMAC: Part 4 Hemodialysis Technicians and 16.12 NMAC: Part 5 Medication Aides.

Persons desiring to present their views on the proposed amendments to the rules may write to request draft copies of the rules from the Board office at 6301 Indian School Rd NE, Suite 710, Albuquerque, NM, 87110, call (505) 841-8340 or download them from www.bon.state.nm.us.
In order for the Board members to review the comments prior to the hearing, persons wishing to submit written comments regarding the proposed rules should submit them to the Board office in writing no later than September 29, 2011. Persons wishing to present written comments at the hearing are asked to provide (10) copies of any comments or proposed changes for distribution to the Board and staff. In addition, persons may present their comments orally at the hearing.

Notice: Any person presenting testimony, who is representing a client, employer or group, must be registered as a lobbyist through the Secretary of State's Office 9505) 827-3600 or do so within 10 days of the Public Hearing.

If you have questions, or if you are an individual with a disability who wishes to attend the hearing or meeting, please call the Board office at (505) 841-8340 at least two weeks prior to the hearing or as soon as possible.

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

NOTICE OF PROPOSED RULEMAKING

The Public Education Department hereby gives notice that the Department will conduct a public hearing at Mabry Hall, Jerry Apodaca Building, 300 Don Gaspar, Santa Fe, New Mexico 87501-2786, on October 17, 2011 from 9:00 a.m. to 10:00 a.m. The purpose of the public hearing will be to obtain input on the following rules:

[*Continued on Page 601*]

Rule Number	Rule Name	Proposed Action
6.60.5 NMAC	School Personnel - General Provisions, Competency Testing for Licensure	Amend
6.30.11 NMAC	Academic Proficiency and Attendance Tied to Instruction Permits	Repeal

Interested individuals may testify either at the public hearing or submit written comments regarding the proposed rulemaking to Matthew Montano, Educator Quality Division, New Mexico Public Education Department, Jerry Apodaca Education Building, 300 Don Gaspar, Santa Fe, New Mexico 87501-2786 (Matthew.montano1@state.nm.us) (505)-827-4522 fax (505) 827-3525.

Written comments must be received no later than 5:00 p.m. on October 17, 2011. However, submission of written comments as soon as possible is encouraged.

The proposed rulemaking actions may be accessed on the Department's website (http://ped.state.nm.us) or obtained from Matthew Montano, Division Manager, Educator Quality Division, New Mexico Public Education Department, Jerry Apodaca Education Building, 300 Don Gaspar, Santa Fe, New Mexico 87501-2786 (Matthew.montano1@state.nm.us) (505)-827-4522 fax (505) 827-3525. The proposed rules will be made available at least thirty days prior to the hearings.

Individuals with disabilities who require this information in an alternative format or need any form of auxiliary aid to attend or participate in this meeting are asked to contact Matthew Montano, (Matthew.montano1@state.nm.us) or at (505)-827-4522 as soon as possible. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

HISTORICAL RECORDS ADVISORY BOARD

Commission of Public Records
New Mexico State Records Center & Archives
1205 Camino Carlos Rey
Santa Fe, New Mexico 87507

NOTICE OF REGULAR MEETING

The New Mexico Historical Records Advisory Board has scheduled a regular meeting for Friday, September 23, 2011 from 9:00 a.m. to 12:00 noon. The meeting will be held at the State Records Center & Archives, 1209 Camino Carlos Rey, Santa Fe, NM. If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any form of auxiliary aid or service to attend or participate in the meeting, please contact Randy Forrester at 505-476-7936 of the State Records Center & Archives at least one week prior to the meeting. Public documents, including the agenda and minutes will be available 24 hours before the meeting.

NOTICE OF RULEMAKING

The New Mexico Historical Records Advisory Board may consider the following items of rulemaking at the meeting:

1.13.5 NMAC NEW MEXICO HISTORICAL RECORDS GRANT PROGRAM

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

TRAINING AND RECRUITING DIVISION

Law Enforcement Academy

Notice

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY
NM LAW ENFORCEMENT ACADEMY
BOARD MEETING AND PUBLIC HEARING

On Wednesday October 19, 2011, at 9:00 a.m., the New Mexico Law Enforcement Academy Board will hold a Regular Board Meeting to include two Public Hearings. The Public Hearings will include 10.29.9 Police Officer and 10.29.7 In Service Training Requirements.

The NMLEA Board Meeting and public hearings will be held at New Mexico Law Enforcement Academy, 4491 Cerrillos Rd. Santa Fe, NM 87507

Copies of the Regular Board Meeting Agenda's and proposed rule changes may be obtained by accessing our website at www.dps.nm.org/training or by calling Gil Najar at (505) 827-9265 or Monique Lopez at (505) 827-9255.

NEW MEXICO RACING COMMISSION

NEW MEXICO RACING COMMISSION
NOTICE OF RULEMAKING AND PUBLIC HEARING

NOTICE IS HEREBY GIVEN that the New Mexico Racing Commission will hold a Regular Meeting and Rule Hearing on September 22, 2011. The hearing will be held during the Commission's regular business meeting, beginning at 8:30 a.m. with executive session. Public session will begin at 10:30 a.m. The meeting will be held in the Boardroom at 4900 Alameda Blvd. NE, Albuquerque, New Mexico.

The purpose of the Rule Hearing is to consider adoption of the proposed amendments and additions to the following Rules Governing Horse Racing in New Mexico No. 15.2.6 NMAC and 15.2.7 NMAC. The comments submitted and discussion heard during the Rule Hearing will be considered and discussed by the Commission during the open meeting following the Rule Hearing. The Commission will vote on the proposed rules during the meeting.

Copies of the proposed rules may be obtained from India Hatch, Agency Director, New Mexico Racing Commission, 4900 Alameda Blvd NE, Suite A, Albuquerque, New Mexico 87113, (505) 222-0700. Interested persons may submit their views on the proposed rules to the commission at the above address and/or may appear at the scheduled meeting and make a brief verbal presentation of their view.

Anyone who requires special accommodations is requested to notify the commission of such needs at least five days prior to the meeting.

_____
India Hatch Agency Director

Dated: August 30, 2011

End of Notices and Proposed Rules Section

Adopted Rules

NEW MEXICO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL OFFICE OF GUARDIANSHIP

This is an amendment to 9.4.21 NMAC, Sections 7 through 11, 13 through 16 and 18, effective 9/15/2011.

9.4.21.7 DEFINITIONS: Unless defined below, terms used in 9.4.21 NMAC correspond to those defined in NMSA 1978, Section 45-5-101 (2009), NMSA 1978, Section 45-1-201 or in NMSA, 1978, Section 43-1-15. The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise.

A. "Complaint" means an allegation of wrongdoing by a contractor or a violation of the contract with the NMDDPC office of guardianship and the contractor, including but not limited to:

(1) failure to provide appropriate services;

(2) violations of the civil rights of the wards; and

(3) abuse, neglect or exploitation of the ward.

B. "Complaint against the office of guardianship" means an allegation of wrongdoing by the NMDDPC office of guardianship or its staff, including but not limited to:

(1) failure to appropriately monitor and supervise contractors;

(2) violations of the due process rights of the protected person or contractor; and

(3) failure to comply with complaint procedures as set forth herein.

[~~B.~~] **C.** "**Comprehensive evaluation**" is an assessment using a variety of diagnostic tools to determine the appropriate level of intervention, if any, in order to maximize self-reliance and independence for a [~~ward~~] protected person as mandated by NMSA 1978, Section 45-5-301.1 (2009).

[~~C.~~] **D. "Contracted guardianship providers"** means some private/public entity or individual under contract with the NMDDPC office of guardianship to act as guardian for an adjudicated incapacitated person who has no family or friends willing, able and appropriate to be his/her guardian.

[~~D.~~] **E. "Contractor"** means an entity or individual under a contract with the NMDDPC office of guardianship to provide some type of guardianship service; i.e., attorneys, court visitors, or guardians.

[~~**E. "Court"** means the district court or family division of the district court where such jurisdiction is conferred.~~]

F. "Designated entity" is a person or organization contracted or appointed by the NMDDPC office of guardianship to conduct the comprehensive evaluations.

[~~G. "Emergency"~~ means ~~any situation in which the physical or mental condition, health status or safety of an incapacitated person is at significant risk due to the unavailability of a substitute decision maker.~~

~~**H. "Functional impairment"** means an impairment that is measured by a person's inability to manage his/her personal care or the person's inability to manage his/her estate or financial affairs or both.~~

~~**I. "Grievance"** means an allegation of wrongdoing by the office of guardianship or its staff, including but not limited to:~~

~~**(1)** failure to appropriately monitor and supervise contractors;~~

~~**(2)** violations of the due process rights of the ward or contractor; and~~

~~**(3)** failure to comply with complaint procedures as set forth herein.~~

~~**J. "Guardian"** means a person who has qualified to provide for the care, custody or control of an incapacitated person pursuant to testamentary or court appointment, but excludes one who is a guardian ad litem.~~

~~**K. "Guardian ad litem"** means an attorney appointed by the court to represent and protect the interests of an incapacitated person in connection with litigation or any other court proceeding.~~

~~**L. "Inability to manage his/her personal care"** means the inability, as evidenced by recent behavior, to meet one's needs for mental or physical health treatment or care resulting in personal neglect of medical care, nutrition, shelter, hygiene or safety so that physical injury, illness or disease has occurred or is likely to occur in the near future.~~

~~**M. "Incapacitated person"** means any person who is found by a court to be impaired to the extent that he/she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his/her person or management of his/her affairs.~~

~~**N. "Interested person"** means any person who has an interest in the welfare of the alleged incapacitated adult to be protected, and may include the NMDDPC office of guardianship.~~

~~**O. "Least restrictive form of intervention"** means only those limitations necessary to provide the needed care and rehabilitative services, and that the adjudicated incapacitated adult shall enjoy the greatest amount of personal freedom and legal rights.~~

~~**P. "Letters"** means letters of guardianship, which provide proof that the guardian of the adjudicated incapacitated adult is a court appointed guardian.~~

~~**Q. "Limited guardian"** means a guardian appointed by the court to exercise limited authority for the incapacitated person as specified in the court order.~~

~~**R. "Limited guardianship"** means the court shall appoint a limited guardian if it determines that the incapacitated person is able to manage some but not all aspects of his/her personal care. The court shall specify those powers that the limited guardian shall have and may further restrict each power so as to permit the incapacitated person to care for himself commensurate with his/her ability to do so. A person for whom a limited guardian has been appointed retains all legal rights except those that have been specifically granted to the limited guardian by the court.~~

~~**S. "Petitioning attorney"** means the attorney who files a petition on behalf of the interested person and represents the interested person and identifies the proposed guardian.~~

~~**T. "Plenary guardian" or "full guardian"** means a guardian appointed by the court to exercise all legal rights and powers of the incapacitated person after the court has found that the incapacitated person lacks the capacity to carry out all the tasks necessary to care for his or her person.~~

~~**U. "Plenary guardianship"** or **"full guardianship"** means the most restrictive form of guardianship and is authorized by a court only when an alleged incapacitated person is found to lack capacity to carry out all of the tasks necessary to care for his or her person and only after less restrictive options have been ruled out.~~

~~**V. "Power of attorney (POA)"** means a document created while a person (principal) has capacity, which grants revocable authority to another person (agent) to act on behalf of the principal in specified areas.~~

~~**(1) "Durable POA"** means the document has language which indicates that it will not be affected by any subsequent incapacity of the principal. Thus, it is considered to be a durable power of attorney.~~

~~**(2) "Springing POA"** means the document contains language which indicates that it only becomes effective upon the incapacity of the principal. Thus,~~

it is considered to be a springing power of attorney.

W. "Qualified health care professional" means a physician, psychologist, nurse practitioner or other health care practitioner whose training and expertise aid in the assessment of functional impairment.

[X.] G. "RFP" means the request for proposal which is the process under state Procurement Code where an individual or non-state agency entity may be awarded a contract to provide services.

[Y. "Substitute judgment" means the standard of decision making for guardians of adults that requires the guardian to ascertain what the decision would have been if the ward were able to make the decision themselves and then make the decision based upon that knowledge.

Z. "Surrogate decision maker" means the individual authorized by the Uniform Health Care Decisions Act to make health care decisions for a patient.

AA. "Temporary guardian" means a person appointed by the court at an expedited hearing to serve as guardian for an alleged incapacitated person. The temporary guardian has specific powers granted by the court to prevent harm to the alleged incapacitated person during the time of his or her appointment.

BB. "Temporary guardianship" means that when a petition for guardianship has been filed alleging that immediate and irreparable harm will result to the alleged incapacitated person if the normal notice and time requirements of a guardianship proceeding are kept, the court may appoint a temporary guardian for the alleged incapacitated person without notice to the alleged incapacitated person. The temporary guardianship shall last not more than sixty days although the court can extend the guardianship for an additional thirty days. A hearing shall be held to determine whether the guardianship will be permanent.

CC. "Testamentary guardian" means a guardian appointed by will or other writing of a parent or spouse guardian pursuant to the procedures outlines in NMSA 45-5-301.

DD. "Testamentary guardianship" means a guardianship that is passed from a spouse or parent guardian to another person through a will or other writing pursuant to the procedures outlined in NMSA 45-5-301.

EE. "Treatment guardian" means a person, appointed by the court pursuant to the Mental Health and Developmental Disabilities Code (NMSA Section 43-1-15), who can make substitute decisions for an incapacitated person regarding mental health treatment, including the use of psychotropic medications, for a specified period of time, not to exceed one year per court appointment.

FF. "Treatment guardianship" means a form of guardianship tailored to grant the guardian authority to make decisions regarding mental health treatment for individuals determined by the court to lack the capacity to provide informed consent for mental health treatment.

GG. "Visitor" or "court visitor" means a person who is an appointee of the court who has no personal interest in the proceeding and who has been trained or has the expertise to appropriately evaluate the needs of the person who is allegedly incapacitated. A "visitor" may include, but is not limited to, a psychologist, social worker, developmental incapacity professional, physical or occupational therapist, an educator or a rehabilitation worker.

HH. "Ward" means an incapacitated person for whom a guardian has been appointed.]

[9.4.21.7 NMAC - N, 4/14/2006; A, 4/30/07; A, 9/15/11]

9.4.21.8 ELIGIBILITY:

A. The alleged incapacitated person must be eighteen (18) years old to qualify for services from the NMDDPC office of guardianship.

B. The alleged incapacitated person must be financially and otherwise eligible for [institutional] medicaid or a similar public benefit.

C. For a guardianship where the proposed guardian is not a contracted service provider, to obtain legal services the proposed guardian's [gross] household income must not exceed [three hundred percent (300%)] 200% of the federally established poverty level as that term is defined by the federal HHS poverty guidelines.

(1) Proof of income is required and is determined [in one of two ways] by the following:

(a) providing the NMDDPC office of guardianship a copy of the proposed guardian's most recent federal income tax return [(first two pages of 1040 or 1041) for the year prior to the year in which application is made] and proof of all income and benefits such as unemployment compensation, child support, food stamps or social security income; or, if no income tax return, by completing a financial eligibility form provided by the office of guardianship; or

(b) proof of qualification by the proposed guardian under any federal or state program with income restrictions equal to or greater than that required above.

(2) At the discretion of the director of the NMDDPC office of guardianship, exceptions may be made for financial hardship.

(3) The NMDDPC office of guardianship may develop a sliding-fee scale for private guardianships for persons who do not meet income eligibility guidelines.

(4) This program is for low income New Mexicans with very limited resources who are unable to pay for private legal services to be appointed as the guardian. The proposed guardian will be required to attest to not having net liquid assets after appropriate exclusions (which are the principal residence, vehicles used for transportation, assets used in producing income and any other asset exempt from attachment under state or federal law) to pay for the legal services. Services may be declined to a proposed guardian whose income is at or below 200% of the federal poverty level if evidence exists of sufficient resources to pay for private legal services.

[D. The alleged incapacitated person must be a legal resident of New Mexico.

E. The alleged incapacitated person must be recently assessed by a qualified health care provider who shall submit a report in writing to the court, which:

(1) describes the nature and degree of the alleged incapacitated person's incapacity, if any, and the level of the alleged incapacitated person's intellectual, developmental and social functioning; and

(2) includes observations and supporting data regarding the alleged incapacitated person's ability to make health care decisions and manage the activities of daily living. NMSA Section 45-5-303D (1993)]

[9.4.21.8 NMAC - N, 4/14/2006; A, 4/30/07; A, 9/15/11]

9.4.21.9 PRIORITIZATION OF SERVICE:

A. In general, service will be provided based on the date of application.

B. When service requests exceed capacity [or availability], funding or resources, individuals in the categories noted in Subparagraph C below will be prioritized to receive the first available services, as appropriate.

C. Priority categories [(all have equal prioritization):

(1) adult protective services (APS) referrals;

(2) Jackson class members;

(3) emergencies, with no family members or friends willing, able and appropriate to serve as guardian;

(4) military veterans.]

(1) high need guardianships:

(a) high need for a guardian of last resort (with no family member or other willing, able and appropriate to serve as guardian) for an adult protective services (APS) referral, military veteran, Jackson class member (former resident of the state

training schools from 1987 to 1997), Foley referral (former resident of the state training schools who was discharged between 1970 and 1987), and others;

(b) high need for a guardian with a family member or other willing, able and appropriate to serve as guardian for a military veteran, Jackson class member or Foley referral (does not include others);

(2) lesser need guardianships:

(a) lesser need for a guardian of last resort for an APS referral, military veteran, Jackson class member or Foley referral (does not include others);

(b) lesser need for guardian with a family member or other willing, able and appropriate to serve as guardian for a military veteran, Jackson class member or Foley referral (does not include others); requests for legal services paid by the state seeking to appoint family members or other willing, able and appropriate to serve as guardian are not in the priority categories unless the person to be served is a military veteran, Jackson class member or Foley referral.

D. If service requests in general, including those from the Subsection C categories above, exceed the NMDDPC office of guardianship's ability to provide services due to limited funding or resources, the NMDDPC office of guardianship may prioritize the requests by rating them according to a referred individual's need for guardianship. Rating criterion may include such factors as the status of an individual's support system, services, finances, medical needs, and safety and stability of placement or residence.

[9.4.21.9 NMAC - N, 4/14/2006; A, 9/15/11]

9.4.21.10 DESIGNATION OF SERVICE AREA: Services are to be provided [~~statewide through the judicial districts. Petitions for guardianship in the state of New Mexico must be filed in the judicial district where the alleged incapacitated person resides~~] throughout the state of New Mexico. The NMDDPC office of guardianship recognizes the individual sovereignty of each tribe and pueblo in the state of New Mexico.

[9.4.21.10 NMAC - N, 4/14/2006; A, 9/15/11]

9.4.21.11 SERVICES TO BE PROVIDED BY THE NMDDPC OFFICE OF GUARDIANSHIP:

A. The provision of [~~probate code~~] adult guardianship services to income eligible, incapacitated persons as follows:

(1) contracting with attorneys to petition for the appointment of probate code guardians;

(2) contracting with entities/ individuals to serve as probate code guardians;

(3) contracting with entities/ individuals to serve as visitors (court visitors) in probate code guardianship proceedings;

(4) contracting with attorneys to serve as guardian ad litem in probate [~~court~~] code guardianship proceedings;

(5) serving as an interested person pursuant to Subsection 6 of Section 28-16B-3, NMSA 1978;

[~~**(5)**~~] **(6)** identifying available persons to serve as mental health treatment guardian;

[~~**(6)**~~] **(7)** contracting to provide for recruitment and training for persons interested in serving as mental health treatment guardians;

[~~(7)~~] (8) providing information regarding the duties and responsibilities of probate code guardianship, including less restrictive alternatives; and

[~~(8)~~] (9) investigating and addressing complaints made against the NMDDPC office of guardianship contractors.

B. The provision of recruitment and training for persons interested in serving as probate code guardians.

C. The provision of information regarding the duties and responsibilities of probate code guardianship, including less restrictive alternatives.

D. The provision of investigative measures/ processes to address complaints made against entities and individuals providing contracted guardianship services.

[9.4.21.11 NMAC - N, 4/14/2006; A, 4/30/07; A, 9/15/11]

9.4.21.13 REFERRAL PROCESS: Any person interested in the well being of an alleged incapacitated person, and seeking guardianship services to be paid for by the NMDDPC office of guardianship, must [~~call or complete a referral process form from NMDDPC office of guardianship~~] submit or have submitted a completed application form and provide supporting documentation to the NMDDPC office of guardianship.

[9.4.21.13 NMAC - N, 04/14/2006; A, 9/15/11]

9.4.21.14 COMPLAINTS AGAINST A CONTRACTED PROVIDER WITH THE NMDDPC OFFICE OF GUARDIANSHIP:

A. A complaint shall be made in writing by the client or another person on behalf of the client, including but not limited to a friend, relative, advocate, or other interested person, such as a caregiver or provider. An exception to the requirement that a complaint shall be made in writing shall be made if a reasonable accommodation is necessary.

B. **[~~With the exception set forth~~]** Except as provided in Subsection [~~E~~] D of 9.4.21.14 NMAC, below, [~~all~~] prior to filing a complaint against a provider contracting with the NMDDPC office of guardianship, individuals [~~registering a complaint~~] shall first try [~~and~~] to resolve their complaints [~~against a~~] with the contracted provider [~~with the office of guardianship~~] through that provider's grievance process.

C. If the complaining party and contractor are unable to reach a resolution or agreement then the complaining party may file a complaint with the office of guardianship and may file a copy with the contractor.

[~~D. Complaining parties may file a simultaneous compliant against a contractor with the office of guardianship. The office of guardianship may choose to postpone intervention pending completion of the contractor's grievance process.~~]

[~~E.~~] D. Exceptions shall be made to Subsections A & B of 9.4.21.14 NMAC when the NMDDPC office of guardianship has reason to believe that an emergency situation exists or that a delay of the investigation could result in harm to the [~~ward~~] protected person or retaliation by the contractor.

[~~F.~~]E. The complaint should include as much information as possible, including the following:

(1) name of the incapacitated person;

(2) name of the contact information for the individual making the complaint on behalf of the incapacitated person;

(3) relationship of the complaining party to the incapacitated person;

(4) name of the individual contractor against whom the complaint is being made;

(5) name of the party who has attempted to resolve the complaint, if known;

(6) what actions have been taken to attempt to resolve the complaint;

[~~**(6)**~~] **(7)** details of the complaint including the alleged wrongdoing, the involved parties and when and where the wrongdoing occurred;

[~~**(7)** where sufficient information is provided to allow the office of guardianship to continue the investigation, the office of guardianship will make further inquiries if possible or discontinue the investigation; justification for closure of investigations based on insufficient information will be documented.~~]

[~~G.~~] F. The complaint made to the office of guardianship may be submitted by mail or fax unless a reasonable accommodation is necessary.

[~~H.~~] G. In order to preserve the confidentiality of the incapacitated person, the complaint shall be submitted to: The

NMDDPC Office of Guardianship; 810 W. San Mateo, Ste. C; Santa Fe, NM 87505-4144; (505) 476-7324; (505) 476-7322 (Fax).

[I.] H. Upon receipt of a verbal or written complaint, the NMDDPC office of guardianship shall:

(1) acknowledge receipt of a the complaint in writing;

(2) notify all parties involved; and

(3) initiate an investigation within 15 working days of the filing of the complaint with the NMDDPC office of the guardianship;

(4) where sufficient information is provided to allow the NMDDPC office of guardianship to continue the investigation, the NMDDPC office of guardianship will make further inquiries if possible or discontinue the investigation; justification for closure of investigations based on insufficient information will be documented.

[J.] I. A determination decision shall be made within 60 working days after the complaint is filed with the NMDDPC office of guardianship unless a shorter time frame is required to protect the [ward] protected person.

[K.] J. A determination decision shall include:

(1) the decision made;

(2) the basis for the decision;

(3) notice of the complaining party's right to file a complaint about the actions taken by the NMDDPC office of guardianship related to the investigational process pursuant to 9.4.21.15 NMAC;

(4) further actions to be taken by the NMDDPC office of guardianship and the contractor which may include, but shall not be limited to:

(a) the imposition of a corrective action plan on the contractor; and

(b) a referral of the complaint to other agencies for investigation and prosecution.

[L.] K. Persons objecting to the process of the complaint investigation taken by the NMDDPC office of guardianship may file a grievance against the NMDDPC office of guardianship with the New Mexico human services department pursuant to 9.4.21.15 NMAC below.

[M.] L. None of these regulations restrict the due process rights of an individual to request a less restrictive guardianship or to overturn the decision of a guardianship contractor or the NMDDPC office of guardianship through a court of law.
[9.4.21.14 NMAC - N, 04/14/2006; A. 04/30/07; A, 9/15/11]

9.4.21.15 [GRIEVANCES] COMPLAINTS AGAINST THE NMDDPC OFFICE OF GUARDIANSHIP: [Grievances] Complaints against the NMDDPC office of guardianship or a staff member of the NMDDPC office of guardianship shall be filed with and investigated by the human services department, by sending a complaint in writing directly to the secretary of human services department with a copy sent to the director of the NMDDPC office of guardianship. (NMSA 2003 28-16B-6E)
[9.4.21.15 NMAC - N, 04/14/2006; A, 9/15/11]

9.4.21.16 TRANSFER OF [WARD] PROTECTED PERSON FROM A PRIVATE PAY GUARDIANSHIP TO A PROGRAM FUNDED THROUGH THE NMDDPC OFFICE OF GUARDIANSHIP:

A. Purpose: It is not the intention of the NMDDPC office of guardianship to create a hardship on any private pay provider of guardianship services in cases where resources are being exhausted, but in order to work in a more collaborative fashion these procedures are being developed to move the private pay [wards] protected persons into the state funded program under the NMDDPC office of guardianship in a timely and reasonable manner to minimize the impact on the [ward] protected person.

B. Requirements: In order to affect a [ward's] protected person's transfer to a program funded through the NMDDPC office of guardianship, the private pay guardianship must do the following:

(1) obtain [a request for transfer form] an application for services from the NMDDPC office of guardianship and fill it out completely (failure to do so will result in delay of transfer);

(2) the filing of the request for [transfer from] services with the NMDDPC office of guardianship does not guarantee the request will be granted;

(3) to be eligible for transfer into this program, a [ward] protected person must [meet the standards for qualifying] be financially eligible for institutional medicaid and medicaid in New Mexico [(if appropriate)];

(4) appropriate [residential] placement must be secured by the private pay guardians for the [ward] protected person prior to transfer to [office of guardianship] a publically funded guardian;

(5) all necessary medical and other information regarding the [ward] protected person must be provided to the new guardian [for the state] in a timely manner;

(6) any original legal documents such as birth certificates, social security cards, medicaid cards, etc. shall be turned over to the new guardian upon appointment;

(7) legal fees for the transferring of the case must be paid by the private provider (this would include the closing of the conservatorship);

(8) if the [ward] protected person has a conservatorship and no assets, then the conservatorship must be closed prior to transfer; if the conservatorship cannot be closed for some appropriate reason, then a complete accounting must be given to the NMDDPC office of guardianship at the time of transfer;

(9) there must be a burial policy for the ward; ownership is to be transferred by the private provider to the NMDDPC office of guardianship's appointed guardian;

[(a)] (10) these transfers will not be given any priority status;

[(b)] (11) the private pay provider will agree to cooperate with the new guardian on matters, including, but not limited to, providing any information the [state provider] new guardian might need, which may be in the possession of the private guardian;

[**(10)**] **(12)** these transfers will be effectuated according to NMSA 1978, Section 45-5-307.
[9.4.21.16 NMAC - N, 04/14/2006; A, 9/15/11]

9.4.21.18 COMPREHENSIVE EVALUATIONS:

A. Depending upon the availability of funding and resources, and unless otherwise provided for by another agency or program, comprehensive evaluations for [wards] protected persons with contracted providers [will occur in the following circumstances:

(1) no comprehensive evaluation has occurred in the last five years

(2) comprehensive evaluations may occur sooner then every five years upon mutual agreement between the NMDDPC office of guardianship and a contracted guardianship provider;

(3) life circumstances resulting in change in condition.] may be obtained through a referral to the NMDDPC office of guardianship by the contract guardian if the protected person appears to have made gains in her/his capacity or to be in need of increased protection or other such that a request for review of the guardianship by the court appears indicated.

B. Comprehensive evaluations will occur in the following manner:

(1) The comprehensive evaluations will be done by the entity designated by the NMDDPC office of guardianship.

(2) [Within thirty (30) days after the professional services contract is signed, all contracted guardianship providers will provide the names of their wards who have not had a comprehensive evaluation in the last five (5) years to the NMDDPC office of guardianship] All contracted guardianship providers will provide the names of their protected persons who meet the criterion

in Subsection A of this section at any time and upon request by the NMDDPC office of guardianship. The referral process will be established by the NMDDPC office of guardianship.

(3) The components of the comprehensive evaluation will be determined by the designated entity after consultation with the guardian.

(4) The designated entity will set up the appointments.

(5) The contracted guardianship provider will provide written authorization for the [~~wards~~] protected person selected for a comprehensive evaluation.

(6) The contracted guardianship provider will provide the following documents at a time and place determined by the designated entity:

(a) name of the [~~ward~~] protected person, living arrangements of the ward, day placement and daily activity, and relevant contact information;

(b) medical history and assessment history of the [~~ward~~] protected person that may come from other state and federal programs such as the DD waiver program, medicaid, schools, division of vocational rehabilitation, commission for the blind, etc.;

(c) the current level of guardianship, and;

(d) any additional information requested by the designated entity relevant to the comprehensive evaluation.

(7) These provisions are in addition to any terms and conditions regarding comprehensive evaluations as set forth in the contract between the NMDDPC office of guardianship and the contracted guardianship provider.

(8) If a [~~ward~~] protected person has undergone some part of the comprehensive evaluation within the last three years, the contracted guardianship provider may request to substitute that part of the evaluation for the report of the evaluation undergone within the last three (3) years. The designated entity may deny the request, based on professional judgment, it should not be substituted. If a substitution is allowed, the contracted guardianship provider will provide the report of that evaluation to the designated entity.

(9) If the contracted guardianship provider has clear and convincing evidence that a [~~ward~~] protected person does not need an evaluation, the contracted guardianship provider will provide to the NMDDPC office of guardianship a short description explaining why the [~~ward~~] protected person should not be evaluated.

(10) The NMDDPC office of guardianship or its agent has the right to review the files and records of any [~~ward~~] protected person under contract between the NMDDPC office of guardianship and a contracted guardianship provider for the purpose of determining whether the [~~ward~~] protected person should have a comprehensive evaluation.

(11) If the NMDDPC office of guardianship determines that a [~~ward~~] protected person should undergo an evaluation, despite the justification provided in Paragraph (9) of Subsection B of 9.4.21.18 NMAC, the NMDDPC office of guardianship will send a letter to the contracted guardianship provider so stating ("Notice Letter"). If, after receipt of the notice letter, the contracted guardianship provider does not agree with the NMDDPC office of guardianship that a [~~ward~~] protected person should undergo an evaluation, the following procedure will commence.

(a) Within ten (10) working days after receiving the notice letter, the contracted guardianship provider will contact the NMDDPC office of guardianship in writing with the basis for its disagreement with the notice letter and during that same time period set up a meeting at the office of the NMDDPC office of guardianship for the purpose of attempting to resolve this issue. The contracted guardianship provider attending the meeting must have full authority to resolve this issue. The proposed location of the meeting will be at the office of the NMDDPC office of guardianship at a day and time proposed by the NMDDPC office of guardianship. The contracted guardianship provider may propose a different time and location. The meeting must be held no more than thirty (30) days from the date of receipt of the notice letter. If the parties cannot agreed on a location and time, the NMDDPC office of guardianship may petition the court pursuant to Subparagraph (d) of Paragraph (11) of Subsection B of 9.4.21.18 NMAC.

(b) If the parties come to an agreement, the [~~ward~~] protected person may or may not undergo an evaluation depending on the agreement reached by the parties.

(c) The NMDDPC office of guardianship will confirm the outcome of the meeting by letter (outcome letter) within two working days of the meeting between the parties.

(d) If there is no agreement, the NMDDPC office of guardianship may, within fourteen (14) working days from the date of the outcome letter, petition the court in which the guardian was appointed to have the [~~ward~~] protected person evaluated.

[9.4.21.18 NMAC - N, 04/30/07; A, 9/15/11]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an emergency amendment to 8.102.500 NMAC, Section 8, effective October 1, 2011.

8.102.500.8 GENERAL REQUIREMENTS:

A. Need determination process: Eligibility for NMW, state funded qualified aliens and EWP cash assistance based on need requires a finding that:

(1) the benefit group's countable gross monthly income does not exceed the gross income limit for the size of the benefit group;

(2) the benefit group's countable net income after all allowable deductions does not equal or exceed the standard of need for the size of the benefit group;

(3) the countable resources owned by and available to the benefit group do not exceed the $1,500 liquid and $2,000 non-liquid resource limits;

(4) the benefit group is eligible for a cash assistance payment after subtracting from the standard of need the benefit group's countable income, and any payment sanctions or recoupments.

B. Gross income limits: The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

(1) Income eligibility limits are revised and adjusted each year in October.

(2) The gross income limit for the size of the benefit group is as follows:

(a) one person [~~$768~~] $772
(b) two persons [~~$1,033~~] $1,042
(c) three persons [~~$1,297~~] $1,313
(d) four persons [~~$1,562~~] $1,584
(e) five persons [~~$1,828~~] $1,854
(f) six persons [~~$2,092~~] $2,125
(g) seven persons [~~$2,357~~] $2,395
(h) eight persons [~~$2,622~~] $2,666
(i) add [~~$265~~] $270 for each additional person.

C. Eligibility for support services only: Subject to the availability of state and federal funds, a benefit group that is not receiving cash assistance but has countable gross income that is less than 100% of the federal poverty guidelines applicable to the size of the benefit group may be eligible to receive services. The gross income guidelines for the size of

the benefit group are as follows:

(1) one person [~~$903~~] $908
(2) two persons [~~$1,215~~] $1,226
(3) three persons [~~$1,526~~] $1,545
(4) four persons [~~$1,838~~] $1,863
(5) five persons [~~$2,150~~] $2,181
(6) six persons [~~$2,461~~] $2,500
(7) seven persons [~~$2,773~~] $2,818
(8) eight persons [~~$3,085~~] $3,136
(9) add [~~$312~~] $319 for each additional person.

D. Standard of need:

(1) The standard of need is based on the number of participants included in the benefit group and allows for a financial standard and basic needs.

(2) Basic needs include food, clothing, shelter, utilities, personal requirements and the participant's share of benefit group supplies.

(3) The financial standard includes approximately $79 per month for each participant in the benefit group.

(4) The standard of need for the NMW, state funded qualified aliens, and EWP cash assistance benefit group is:

(a) one person $ 266
(b) two persons $ 357
(c) three persons $ 447
(d) four persons $ 539
(e) five persons $ 630
(f) six persons $ 721
(g) seven persons $ 812
(h) eight persons $ 922
(i) add $91 for each additional person.

E. Special needs:

(1) Special clothing allowance: A special clothing allowance may be issued to assist in preparing a child for school, subject to the availability of state or federal funds and a specific allocation of the available funds for this allowance.

(a) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age if the child is six years of age or older and less than age 19 by the end of August.

(b) The clothing allowance shall be allowed for each school-age child who is included in the NMW, TBP, state funded qualified aliens, or EWP cash assistance benefit group, subject to the availability of state or federal funds.

(c) The clothing allowance is not allowed in determining eligibility for NMW, TBP, state funded qualified aliens, or EWP cash assistance.

(2) Layette: A one-time layette allowance of $25 is allowed upon the birth of a child who is included in the benefit group. The allowance shall be authorized by no later than the end of the month following the month in which the child is born.

(3) Special circumstance: Dependent upon the availability of funds and in accordance with the federal act, the HSD secretary, may establish a separate, non-recurring, cash assistance program that may waive certain New Mexico Works Act requirements due to a specific situation. This cash assistance program shall not exceed a four month time period, and is not intended to meet recurrent or ongoing needs.

F. Non-inclusion of legal guardian in benefit group: Based on the availability of state and federal funds, the department may limit the eligibility of a benefit group due to the fact that a legal guardian is not included in the benefit group.

[8.102.500.8 NMAC - Rp 8.102.500.8 NMAC, 07/01/2001; A, 10/01/2001; A, 10/01/2002; A, 10/01/2003; A/E, 10/01/2004; A/E, 10/01/2005; A, 7/17/2006; A/E, 10/01/2006; A/E, 10/01/2007; A, 11/15/2007; A, 01/01/2008; A/E, 10/01/2008; A, 08/01/2009; A, 08/14/2009; A/E, 10/01/2009; A, 10/30/2009; A, 01/01/2011; A, 01/01/2011; A, 07/29/2011; A/E, 10/01//2011]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an emergency amendment to 8.106.500 NMAC, Section 8, effective October 1, 2011.

8.106.500.8 GA - GENERAL REQUIREMENTS:

A. Limited state funds may result in a suspension or reduction in general assistance benefits without eligibility and need considered.

B. Need determination process: Eligibility for the GA program based on need requires a finding that the:

(1) countable resources owned by and available to the benefit group do not exceed either the $1500 liquid or $2000 non-liquid resource limit;

(2) benefit group's countable gross earned and unearned income does not equal or exceed eighty-five percent (85%) of the federal poverty guideline for the size of the benefit group; and

(3) benefit group's countable net income does not equal or exceed the standard of need for the size of the benefit group.

C. GA payment determination: The benefit group's cash assistance payment is determined after subtracting from the standard of need the benefit group's countable income and any payment sanctions or recoupments.

D. Gross income test: The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent (85%) of the federal poverty guidelines for the size of the benefit group.

(1) Income eligibility limits are revised and adjusted each year in October.

(2) The gross income limit for the size of the benefit group is as follows:

(a) one person [~~$768~~] $772
(b) two persons [~~$1,033~~] $1,042

(c) three persons [~~$1,297~~] $1,313
(d) four persons [~~$1,562~~] $1,584
(e) five persons [~~$1,828~~] $1,854
(f) six persons [~~$2,092~~] $2,125
(g) seven persons [~~$2,357~~] $2,395
(h) eight persons [~~$2,622~~] $2,666
(i) add [~~$265~~] $270 for each additional person.

E. Standard of need:

(1) As published monthly by the department, the standard of need is an amount provided to each GA cash assistance benefit group on a monthly basis and is based on availability of state funds, the number of individuals included in the benefit group, number of cases, number of applications processed and approved, application approval rate, number of case closures, IAR caseload number and expenditures, and number of pending applications.

(2) Basic needs include food, clothing, shelter, utilities, personal requirements and an individual benefit group member's share of supplies.

(3) Notice: The department shall issue prior public notice identifying any change(s) to the standard of need amounts for the next quarter, as discussed at 8.106.630.11 NMAC.

F. Net income test: The total countable earned and unearned income of the benefit group after all allowable deductions cannot equal or exceed the standard of need for the size of the GA benefit group.

G. Special clothing allowance for school-age dependent children: A special clothing allowance may be issued to assist in preparing a child for school, subject to the availability of state or federal funds and a specific allocation of the available funds for this allowance.

(1) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age if the child is six years of age or older and less than age nineteen (19) by the end of August.

(2) The clothing allowance shall be allowed for each school-age child who is included in the GA cash assistance benefit group, subject to the availability of state or federal funds.

(3) The clothing allowance is not counted in determining eligibility for GA cash assistance.

H. Supplemental issuance: A one time supplemental issuance may be distributed to recipients of GA for disabled adults based on the sole discretion of the secretary of the human services department and the availability of state funds.

(1) The one time supplemental issuance may be no more than the standard GA payment made during the month the GA payment was issued.

(2) To be eligible to receive the one time supplement, a GA application must be active and determined eligible no later than the last day of the month in the month the one time supplement is issued.

[8.106.500.8 NMAC - N, 07/01/2004; A/E, 10/01/2004; A/E, 10/01/2005; A, 7/17/2006; A/E, 10/01/2006; A/E, 10/01/2007; A, 01/01/2008; A, 06/16/2008; A/E, 10/01/2008; A, 07/01/2009; A/E, 10/01/2009; A, 10/30/2009; A, 12/01/2009; A, 01/01/2011; A, 07/29/2011; A/E, 10/01/2011]

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an emergency amendment to 8.139.500 NMAC, Section 8, effective October 1, 2011.

8.139.500.8 BASIS OF ISSUANCE

A. Income standards: Determination of need in the food stamp program is based on federal guidelines. Participation in the program is limited to households whose income is determined to be a substantial limiting factor in permitting them to obtain a nutritious diet. The net and gross income eligibility standards are based on the federal income poverty levels established in the Community Services Block Grant Act [42 USC 9902(2)].

B. Gross income standards: The gross income eligibility standards for the 48 contiguous states, District of Columbia, Guam and the Virgin Islands is 130 percent (130%) of the federal income poverty levels for the 48 states and the District of Columbia. One hundred thirty percent (130%) of the annual income poverty guidelines is divided by 12 to determine monthly gross income standards, rounding the results upward as necessary. For households larger than eight, the increment in the federal income poverty guidelines is multiplied by 130%, divided by 12, and the results rounded upward if necessary.

C. Net income standards: The net income eligibility standards for the 48 contiguous states, District of Columbia, Guam and the Virgin Islands are the federal income poverty levels for the 48 contiguous states and the District of Columbia. The annual income poverty guidelines are divided by 12 to determine monthly net income eligibility standards, (results rounded upward if necessary). For households larger than eight, the increment in the federal income poverty guidelines is divided by 12, and the results rounded upward if necessary.

D. Yearly adjustment: Income eligibility limits are revised each October 1st to reflect the annual adjustment to the federal income poverty guidelines for the 48 contiguous states and the District of Columbia.

E. Issuance table: The issuance table lists applicable income guidelines used to determine food stamp (FS) eligibility based on household size. Some amounts are increased to meet the needs of certain categorically eligible households. Some of the net income amounts listed are higher than the income limits for some household sizes. Households not categorically eligible for FS benefits must have income below the appropriate gross income limit for household size.

Household Size	Maximum Gross Monthly Income Categorical Eligibility at 165% of Poverty	Maximum Gross Monthly Income At 130% of Poverty	Maximum Net Monthly Income At 100% of Poverty	Maximum Allotment (benefit amount)
1	[~~$1,490~~] $1,498	[~~$1,174~~] $1,180	[~~$ 903~~] $908	$200
2	[~~$2,004~~] $2,023	[~~$1,579~~] $1,594	[~~$1,215~~] $1,226	$367
3	[~~$2,518~~] $2,548	[~~$1,984~~] $2,008	[~~$1,526~~] $1,545	$526
4	[~~$3,032~~] $3,074	[~~$2,389~~] $2,422	[~~$1,838~~] $1,863	$668
5	[~~$3,547~~] $3,599	[~~$2,794~~] $2,836	[~~$2,150~~] $2,181	$793
6	[~~$4,061~~] $4,124	[~~$3,200~~] $3,249	[~~$2,461~~] $2,500	$952
7	[~~$4,575~~] $4,649	[~~$3,605~~] $3,663	[~~$2,773~~] $2,818	$1,052
8	[~~$5,089~~] $5,175	[~~$4,010~~] $4,077	[~~$3,085~~] $3,136	$1,202
$Each Additional Member	[~~+$515~~] +$526	[~~+$406~~] +$414	[~~+$312~~] +$319	+$150

F. Deductions and standards:

(1) Determination: Expense and standard deduction amounts are determined by federal guidelines and may be adjusted each year. Households eligible based on income and resource guidelines, and other relevant eligibility factors, are allowed certain deductions to determine countable income.

(2) Yearly adjustment: The expense and standard deductions may change each year. If federal guidelines mandate a change, it is effective each October 1st.

(3) Expense deductions and standards table:

Standard Deduction for Household Size of 1 through 3 Standard Deduction for Household of 4 Standard Deduction for Household Size of 5 Standard Deduction for Household Size of 6 or more	[~~$142.00~~] $147.00 [~~$153.00~~] $155.00 [~~$179.00~~] $181.00 [~~$205.00~~] $208.00
Earned Income Deduction (EID)	20%
Dependent Care Deduction	Actual Amount
Heating/Cooling Standard Utility Allowance (HCSUA) Limited Utility Allowance (LUA) Telephone Standard (TS)	[~~$261.00~~] $275.00 [~~$101.00~~] $100.00 [~~$ 36.00~~] $35.00
Excess Shelter Cost Deduction Limit for Non-Elderly/Disabled Households	[~~$458.00~~] $459.00
Homeless Household Shelter Standard	$143.00
Minimum Allotment for Eligible One-and Two-Person Households	$16.00

[02/1/95, 10/01/95, 02/29/96, 10/01/96, 3/15/97, 01/15/98, 11/15/98, 12/15/99, 01/01/01, 03/01/01; 8.139.500.8 NMAC - Rn, 8 NMAC 3.FSP.501, 05/15/2001; A, 10/01/2001; A, 10/01/2002, A, 09/01/2003; A, 10/01/2003; A/E, 10/01/2004; A/E, 10/01/2005; A/E, 10/01/2006; A/E, 10/01/2007; A/E, 10/01/2008; A/E, 04/01/2009; A/E, 10/01/2009; A, 10/30/2009; A, 04/01/2010; A/E, 10/01/2010; A/E, 10/01/2011]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.315.4 NMAC, Sections 9, 11, 12, 15, 16, 18 - 20, 22 and 23, effective September 15, 2011.

8.315.4.9 PERSONAL CARE OPTION SERVICES: Personal care option (PCO) services have been established by the New Mexico human services department (HSD), medical assistance division (MAD or medicaid) to assist individuals 21 years of age or older who are eligible for full medicaid coverage and meet the nursing facility (NF) level of care (LOC) criteria, see, *long term care services utilization review instructions for nursing facilities* which is attached to this part of the NMAC as attachment II. These regulations describe PCO services for consumers who are unable to perform at least two activities of daily living (ADLs) because of disability or functional limitation and need assistance with certain ADLs and instrumental activities of daily living (IADLs) as described in attachment I to this part of the NMAC.

A. A third-party assessor (TPA) determines medical LOC for PCO eligibility upon initial application and at least annually thereafter. Medicaid-eligible individuals may contact the TPA or the managed care organization (MCO) for coordinated long-term care services (CoLTS) (if applicable) to apply for PCO services.

B. The goals of PCO services are to avoid institutionalization and to maintain the individual's functional level and independence. Although an individual's assessment for the amount and types of services may vary, PCO services are not provided 24 hours a day.

C. PCO is a medicaid service, not a medicaid category of assistance, and services under this option are delivered pursuant to an IPoC. PCO services include a range of ADL and IADL services to consumers who are unable to perform at least two ADLs because of [a] disability or [a] functional limitation(s). Consumers will be assessed for services at least annually, or more frequently, as appropriate. PCO services will not include those services for tasks the individual is already receiving from other sources including tasks provided by natural supports. Natural supports are

friends, family, and the community (through individuals, clubs and organizations) that are able and consistently available to provide supports and services to the consumer. [~~The assessment for services~~] The PCO service assessment is conducted pursuant to 8.315.4.19 NMAC, *assessments for services*. The PCO service assessment is performed by the TPA for fee-for-service (FFS) or the MCO for CoLTS[~~. The PCO service assessment will determine~~] and determines the amount and type of services needed to supplement the services a consumer is already receiving including those services provided by natural supports. PCO services must be related to the individual's [~~impairment rating~~] functional level to perform ADLs and IADLs as indicated in the [~~personal care options~~] PCO service assessment and applied to the PCO service guide, MAD 055.[~~, which is~~] The MAD 055 is attached to this part of the NMAC as attachment I.

[8.315.4.9 NMAC - Rp, 8.315.4.9 NMAC, 12-30-10; A, 9-15-11]

8.315.4.11 CONSUMER'S RESPONSIBILITIES: Consumers receiving PCO services have certain responsibilities depending on the service delivery model they choose.

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

(1) verifying that services have been rendered by signing accurate time sheets/logs being submitted to the PCO agency for payroll;

(2) taking the medical assessment form [~~(ISD 379)~~] (MAD 379) once a year to his/her physician (a physician's assistant, nurse practitioner or clinical nurse specialist may also sign the [~~ISD 379~~] MAD 379 in the place of a physician for PCO services only) for completion and submitting the completed form and a current history and physical (H&P) completed within 12 months of the assessment date to the TPA for FFS or the MCO for CoLTS for review by the TPA; this must be done as required prior to [~~his/her LOC expiring~~] the expiration of the approved NF LOC to ensure that there will be no break in services; a consumer who does not submit a timely [~~ISD 379~~] MAD 379 and current H&P to the TPA for FFS or the MCO for CoLTS to forward to the TPA, may experience a break in services; in addition, the consumer must allow the TPA for FFS and the MCO for CoLTS, as applicable, to complete assessment visits and other contacts necessary to avoid a break in services;

(3) participating in the development and review of the IPoC;

(4) [~~maintain~~] maintaining proof of current vehicle insurance (as mandated by the laws of the state of New Mexico) if the attendant will transport the consumer in the consumer's vehicle for support services that have been allocated to the consumer; and

(5) complying with all medicaid rules, regulations, and PCO service requirements; failure to comply could result in discontinuation of PCO services.

B. The consumer's or the consumer's legal representative's responsibilities under the **consumer-directed model** include:

(1) interviewing, hiring, training, terminating and scheduling personal care attendants; this includes, but is not limited to:

(a) verifying that the attendant possesses a current and valid state driver's license if there are any driving-related activities listed on the IPoC; a copy of the current driver's license must be maintained in the attendant's personnel file at all times; if no driving-related activities are listed on the IPoC, a copy of a valid state ID is kept in the attendant's personnel file at all times;

(b) verifying that the attendant has proof of current liability vehicle insurance if the consumer is to be transported in the attendant's vehicle at any time; a copy of the current proof of insurance must be maintained in the attendant's personnel file at all times; and

(c) identifying training needs; this includes training his/her own attendant(s) or arranging for training for the attendant(s);

(2) developing a list of attendants who can be contacted when an unforeseen event occurs that prevents the consumer's regularly scheduled attendant from providing services; making arrangements with attendants to ensure coverage and notifying the agency when arrangements are changed;

(3) verifying that services have been rendered by completing, dating, signing and submitting documentation to the agency for payroll; a consumer or his/her legal representative is responsible for ensuring the submission of accurate timesheets/logs; payment shall not be issued without appropriate documentation;

(4) notifying the agency, within one working day, of the date of hire or the date of termination of his/her attendant and ensure that all relevant employment paperwork and other applicable paperwork is completed and submitted; this may include, but is not limited to: employment application, verification from the employee abuse registry, criminal history screening, doctor's release to work (when applicable), photo identification, proof of eligibility to work in the United States (when applicable), copy of a state driver's license and proof of insurance (as appropriate);

(5) notifying and submitting a report of an incident (as described in Paragraph (14), Subsection B of 8.315.4.12 NMAC) to the PCO agency within 24 hours of such incident, so that the PCO agency can submit an incident report on behalf of the consumer; the consumer or his/her legal representative is responsible for completing the incident report;

(6) ensuring that the individual selected for hire has submitted [~~to~~] a request for a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq. of the Caregivers Criminal History Screening Act, within 20-calendar days of the individual beginning employment; the consumer must work with the selected agency to complete all paperwork required for submitting to the nationwide caregiver criminal history screening; the consumer may conditionally (temporarily) employ the individual contingent upon the receipt of written notice that the individual has submitted to a nationwide caregiver criminal history screening; a consumer may not continue employing an attendant who does not successfully pass a nationwide criminal history screening;

(7) obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCO services while under the influence of drugs or alcohol and, therefore, acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated and a copy of the signed agreement must be given to the PCO agency;

(8) ensuring that if the attendant is the consumer's legal representative and is the individual selected for hire, prior approval has been obtained from medicaid or its designee; any PCO services provided by the consumer's legal representative *MUST* be justified, in writing, by the PCO agency and consumer and submitted for approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure services were provided; documentation of written approval by medicaid or its designee must be maintained in the consumer's file; the consumer is responsible for immediately informing the agency if the consumer has appointed or obtained a legal representative any time during the plan year;

(9) signing an agreement accepting responsibility for all aspects of care and training including mandatory training in cardiopulmonary resuscitation (CPR) and first aid for all attendants, competency testing, tuberculosis (TB) testing, hepatitis B immunizations or waiving the provision of such training and accepting the consequences of such a waiver;

(10) verifying initially prior to employment, and annually thereafter, that

attendants are not on the employee abuse registry by researching the Consolidated Online Registry (COR) pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA, Section 27-7A-1 et seq.;

(11) taking the medical assessment form [~~(ISD 379)~~] (MAD 379) or successor document once a year to his/her physician (physician's assistant, nurse practitioner or clinical nurse specialist) for completion and submitting the completed form and current H&P to the TPA for FFS or MCO for CoLTS, as applicable, for review; this must be done at least 60 days prior to [~~his/her LOC expiring~~] the expiration of the approved NF LOC to ensure that there will be no break in services; a consumer who does not submit a timely [~~ISD 379~~] MAD 379 and current H&P may experience a break in service; in addition, the consumer must allow the TPA for FFS and the MCO for CoLTS, as applicable, to complete assessment visits and other contacts necessary to avoid a break in services;

(12) participating in the development and review of the IPoC;

(13) [~~maintain~~] maintaining proof of current vehicle insurance (as mandated by the laws of the state of New Mexico) if the attendant will transport the consumer in the consumer's vehicle for support services that have been allocated to the consumer;

(14) a consumer that authorizes services when he/she does not have a currently approved LOC or IPoC is liable for payment of those services, that are not eligible for medicaid reimbursement; and

(15) complying with all medicaid rules, regulations, and PCO service requirements; failure to comply could result in discontinuation of PCO services.

C. Consumers may have a personal representative assist him/her giving instruction to the personal care attendant or provide information to the TPA or MCO during assessments of the consumer's natural supports and service needs. A personal representative is not the same as a legal representative, but may be the same person, as appropriate. A personal care representative must have the following qualifications: be at least 18 years of age, have a personal relationship with the consumer and understand the consumer's natural supports and service support needs, and know the consumer's daily schedule and routine (to include medications, medical and functional status, likes and dislikes, strengths and weaknesses). A personal representative does not make decisions for the consumer unless he/she is also a legal representative, but may assist the consumer in communicating, as appropriate. A personal representative may not be a personal care attendant, unless he/she is also the legal representative and has obtained written approval from MAD or its designee pursuant to these PCO regulations. A person's status as a personal representative must be properly documented with the PCO agency.

[8.315.4.11 NMAC - Rp, 8.315.4.11 NMAC, 12-30-10; A, 9-15-11]

8.315.4.12 ELIGIBLE PCO AGENCIES: PCO agencies electing to participate in providing PCO services must obtain certification and have various responsibilities for complying with the requirements for provision of PCO services.

A. **PCO agency certification:** A PCO agency providing either the consumer-directed, the consumer-delegated or both models, must adhere to the requirements of this section. PCO agencies must be certified by medicaid or its designee. An agency listing, by county, is maintained by medicaid or its designee. All certified PCO agencies are required to select a county in which to establish and maintain an official office for conducting of business with published phone number and hours of operation; the PCO agency must provide services in all areas of the county in which the main office is located. The PCO agency may elect to serve any county within 100 miles of the main office. The PCO agency may elect to establish branch office(s) within 100 miles of the main office. The PCO agency must provide PCO services to all areas of any county(ies) selected to provide services. To be certified by medicaid or its designee, agencies must meet the following conditions and submit a packet (contents of paragraphs one through six described below) for approval to medicaid's fiscal agent or its designee containing the following:

(1) a completed medicaid provider participation agreement (PPA also known as the MAD 335);

(2) copies of successfully passed nationwide caregivers criminal history screenings on employees who meet the definition of "caregiver" and "care provider" pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act;

(3) a copy of a current and valid business license or documentation of non-profit status; if certified, a copy of the business license or documentation of non-profit status must be kept current and submitted annually;

(4) proof of liability and workers' compensation insurance; if certified, proof of liability and workers' compensation insurance must be submitted annually;

(5) a copy of written policies and procedures that address:

(a) medicaid's PCO provider rules and regulations;

(b) personnel policies; and

(c) office requirements that include but are not limited to:

(i) contact information, mailing address, physical location if different from mailing address, and hours of operation for the main office and branch offices if any; selected counties for the area(s) of service;

(ii) meeting all Americans with Disabilities Act (ADA) requirements; and

(iii) if PCO agencies have branch offices, the branch office must have a qualified on-site administrator to handle day-to-day operations who receives direction and supervision from the main/central office;

(d) quality improvement to ensure adequate and effective operation, including documentation of quarterly activity that addresses, but is not limited to:

(i) service delivery;

(ii) operational activities;

(iii) quality improvement action plan; and

(iv) documentation of quality improvement activities;

(e) agency operations to furnish services either as a consumer-directed or as a consumer-delegated, or both;

(6) a copy of a current and valid home health license, issued by the department of health, division of health improvement, licensing and certification (pursuant to 7.28.2 NMAC) may be submitted in lieu of requirements Paragraph (3) and Subparagraphs (b) and (d) of Paragraph (5) above; if certified, a copy of a current and valid home health license must be submitted annually along with proof of liability and workers' compensation insurance;

(7) if the agency requests approval to provide the consumer-delegated model of service, a copy of the agency's written competency test for attendants approved by medicaid or its designee; an agency may select to purchase a competency test or it may develop its own test; the test must address at least the following:

(a) communication skills;

(b) patient/client rights, including respect for cultural diversity;

(c) recording of information for patient/client records;

(d) nutrition and meal preparation;

(e) housekeeping skills;

(f) care of the ill and disabled, including the special needs populations;

(g) emergency response (including CPR and first aid);

(h) universal precautions and basic infection control;

(i) home safety including oxygen and fire safety;

(j) incident management and reporting; and

(k) confidentiality;

(8) after the packet is received,

reviewed, and approved in writing by medicaid or its designee, the agency will be contacted to complete the rest of the certification process; this will require the agency to:

(a) attend a mandatory medicaid or its designee's provider training session prior to the delivery of PCO services; and

(b) possess a letter from medicaid or its designee changing provider status from "pending" to "active";

(9) an agency will not be certified as a personal care agency if:

(a) it is owned in full or in part by a professional authorized to complete the medical assessment form [~~(ISD 379)~~] (MAD 379) or other similar assessment tool subsequently approved by medicaid under PCO or the agency would have any other actual or potential conflict of interest; or

(b) the agency is authorized to carry out PCO TPA responsibilities, such as in-home assessments, or the agency would have any other actual or potential conflict of interest; and

(c) a conflict of interest is presumed between people who are related within the third degree of blood or consanguinity or when there is a financial relationship between:

(i) persons who are related within the third degree of consanguinity (by blood) or affinity (by marriage) including a person's spouse, children, parents (first degree by blood); siblings, half-siblings, grandchildren or grandparents (second degree by blood and uncles, aunts, nephews, nieces, great grandparents, and great grandchildren (third degree by blood); stepmother, stepfather, mother-in-law, father-in-law (first degree by marriage); stepbrother, stepsister, brothers-in-law, sisters-in-law, step grandchildren, grandparents (second degree by marriage); step uncles, step aunts, step nephews, step nieces, step great grandparents, step great grandchildren (third degree by marriage);

(ii) persons or entities with an ongoing financial relationship with each other including a personal care provider whose principals have a financial interest in an entity or financial relationship with a person who is authorized to complete an [~~ISD 379~~] MAD 379 or other similar assessment tool or authorized to carry out any of the TPA's responsibilities; a financial relationship is presumed between spouses.

B. **Approved PCO agency responsibilities:** A personal care agency electing to provide PCO services under either the consumer-directed model or the consumer-delegated model, or both, is responsible for:

(1) furnishing services to medicaid consumers that comply with all specified medicaid participation requirements outlined in 8.302.1 NMAC, *General Provider Policies*;

(2) verifying every month that all consumers are eligible for full medicaid coverage and PCO services prior to furnishing services pursuant to Subsection A of 8.302.1.11 NMAC, *provider responsibilities and requirements*; PCO agencies must document the date and method of eligibility verification; possession of a medicaid card does not guarantee a consumer's financial eligibility because the card itself does not include financial eligibility, dates or other limitations on the consumer's financial eligibility; PCO agencies must notify consumers who are not financially eligible that he/she cannot authorize employment for his/her attendant(s) until financial eligibility is resumed; PCO agencies and consumers cannot bill medicaid or its designee for PCO services rendered to the consumer if he/she is not eligible for PCO services;

(3) maintaining appropriate recordkeeping of services provided and fiscal accountability as required by the PPA;

(4) maintaining records, as required by the PPA and as outlined in 8.302.1 NMAC, *General Provider Policies*, that are sufficient to fully disclose the extent and nature of the services furnished to the consumers;

(5) passing random and targeted audits, conducted by medicaid or its designee, that ensure agencies are billing appropriately for services rendered; medicaid or its designee will seek recoupment of funds from agencies when audits show inappropriate billing or inappropriate documentation for services;

(6) providing either the consumer-directed or the consumer-delegated models, or both models;

(7) furnishing their consumers, upon request, with information regarding each model; if the consumer chooses a model that an agency does not offer, the agency must refer the consumer to medicaid or medicaid's designee for a list of agencies that offer that model; the TPA for FFS or the MCO for CoLTS is responsible for explaining each model in detail to consumers on an annual basis;

(8) ensuring that each consumer receiving PCO services has a current, approved IPoC on file;

(9) performing the necessary nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq. of the Caregivers Criminal History Screening Act, on all potential personal care attendants; nationwide caregiver criminal history screenings must be performed by an agency certified to conduct such checks; the agency, along with the consumer, as applicable ensures the paperwork is submitted within the first 20-calendar days of hire; consumers under the consumer-directed model or agencies under the consumer-delegated model may conditionally (temporarily) employ an attendant until such check has been returned from the certified agency; if the attendant does not successfully pass the nationwide caregiver criminal history screening, the agency under consumer-delegated or the consumer under consumer-directed may not continue to employ the attendant;

(10) producing reports or documentation as required by medicaid or its designee;

(11) verifying that consumers will not be receiving services through the following programs while they are receiving PCO services: medicaid home and community-based services (HCBS) waivers with the exception of the CoLTS (c) HCBS waiver, also known as the disabled and elderly (D&E) HCBS waiver, medicaid certified [~~NF~~] nursing facility (NF), intermediate care facility/mentally retarded (ICF/MR), program of all-inclusive care for the elderly (PACE), or adult protective services (APS) attendant care program; an individual residing in a NF or ICF/MR or receiving a non-qualifying HCBS waiver is eligible to apply for PCO services; recipients of community transition goods or services may also receive PCO services; all individuals must meet the medicaid and LOC eligibility requirements to receive PCO services; the TPA, medicaid, or its designee must conduct an assessment or evaluation to determine if the transfer is appropriate and if PCO services would be able to meet the needs of that individual;

(12) processing all claims for PCO services in accordance with the billing specifications from medicaid for FFS or the MCO for CoLTS, as appropriate; payment shall not be issued without appropriate documentation;

(13) making a referral to an appropriate social service, legal, or state agency, or the MCO for CoLTS for assistance, if the agency questions whether the consumer is able to direct his/her own care or is non-compliant with medicaid rules and regulations;

(14) immediately reporting abuse, neglect or exploitation pursuant to NMSA 1978, Section 27-7-30 and in accordance with the Adult Protective Services Act, by fax, within 24 hours of the incident being reported to the agency; reportable incidents may include but are not limited to abuse, neglect and exploitation as defined below:

(a) abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a consumer;

(b) neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or

mental illness to a consumer;

(c) exploitation is defined as the deliberate misplacement or wrongful, temporary or permanent use of a consumer's belongings or money without the voluntary and informed consent of the consumer;

(15) submitting written incident reports to medicaid or its designee, and the MCO for CoLTs consumers, on behalf of the consumer, within 24 hours of the incident being reported to the PCO agency; the PCO agency must provide the consumer with an appropriate form for completion; reportable incidents may include, but are not limited to:

(a) death of the consumer:

(i) unexpected death is defined as any death of an individual caused by an accident, or an unknown or unanticipated cause;

(ii) natural/expected death is defined as any death of an individual caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death;

(b) other reportable incidents:

(i) environmental hazard is defined as an unsafe condition that creates an immediate threat to life or health of a consumer;

(ii) law enforcement intervention is defined as the arrest or detention of a person by a law enforcement agency, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility;

(iii) emergency services refers to admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care that is not anticipated for this consumer and that would not routinely be provided by a primary care provider;

(iv) any reports made to APS;

(16) informing the consumer and his/her attendant of the responsibilities of the agency;

(17) develop an IPoC based on the assessment, services authorization, task list, and consideration of natural supports provided by the TPA for FFS or MCO for CoLTS;

(18) provide an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;

(19) identifying a consumer with an improved or declining health condition or whose needs have changed (i.e. more or less natural supports) and believe the consumer is in need of more or fewer services should send written notification to the TPA for an LOC determination and the TPA for FFS or MCO for CoLTS for additional assessment of need of services;

(20) except for the CoLTS (c) HCBS waiver, agencies who are providing PCO services to a consumer who becomes eligible for a non-CoLTS (c) HCBS waiver must coordinate with the consumer's service coordinator to ensure that the consumer does not experience a break in service or that services do not overlap; coordination must include the effective date PCO services are to stop and non-CoLTS (c) HCBS waiver services are to begin;

(21) maintaining documentation in the consumer's file regarding legal and personal representatives, as applicable; and

(22) cooperating with the TPA or MCO in locating and assisting the consumer with submitting the necessary paperwork for an LOC determination.

C. **For agencies providing PCO services under the consumer-directed model**, the responsibilities include:

(1) providing services through an agency with choice model or as a fiscal employer agent, and complying with all applicable state and federal employment laws as applicable to the provision of such services;

(a) agency with choice, in which the agency is the legal employer of the personal care attendant and the consumer is the managing employer and the agency maintains at least quarterly in-person contact with the consumer, or

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

(2) obtaining from the consumer or his/her legal representative a signed agreement with the attendant in which the attendant agrees that he/she will not provide PCO services while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated; the agency must maintain a copy of the signed agreement in the attendant's personnel file, for the consumer;

(3) obtaining a signed agreement from each consumer accepting responsibility for all aspects of care and training including mandatory training in CPR and first aid for all attendants, competency testing, TB testing, hepatitis B immunizations or a waiver of providing such training and accepting the consequences thereof, and supervisory visits are not included in the consumer-directed option; a copy of the signed agreement must be maintained in the consumer's file;

(4) verifying that if the consumer has selected the consumer's legal representative as the attendant, the consumer has obtained prior approval from medicaid or its designee; any personal care services provided by the consumer's legal representative *MUST* be justified, in writing, by the agency and consumer and submitted for approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure that services were provided; documentation of written approval by medicaid or its designee must be maintained in the consumer's file; the agency must inform the consumer that if the consumer is appointed or selects a legal representative any time during the plan year, the consumer must notify the agency immediately and the agency must ensure appropriate documentation is maintained in the consumer's file;

(5) establishing and explaining to the consumer the necessary payroll documentation needed for reimbursement of PCO services, such as time sheets/logs and tax forms;

(6) performing payroll activities for the attendants, such as, but not limited to, state and federal income tax, social security withholdings and make payroll liability payments as required;

(7) arranging for state of New Mexico unemployment coverage and workers' compensation insurance for all attendants;

(8) informing the consumer of available resources for necessary training, if requested by the consumer, in the following areas: hiring, recruiting, training, supervision of attendants, advertising, and interviewing techniques;

(9) making a referral to an appropriate social service agency, legal agency(s) or medicaid designee for assistance, if the agency questions whether the consumer is able to direct his/her own care; and

(10) maintaining a consumer file and an attendant personnel file for the consumer for a minimum of six years.

D. **For agencies providing PCO services under the consumer-delegated model,** the responsibilities include, but are not limited to the following:

(1) employing, terminating and scheduling qualified attendants;

(2) conducting or arranging for training of all attendants for a minimum of 12-hours per year; initial training must be completed within the first three months of employment and must encompass:

(a) an overview of PCO services;

(b) living with a disability or chronic illness in the community;

(c) CPR and first aid training; and

(d) a written competency test with a minimum passing score of 80 percent or better; expenses for all trainings are to be incurred by the agency; other trainings may take place throughout the year as determined by the agency; the agency must maintain in the attendant's file: copies of all trainings, certifications, and specialty training the

attendant completed; CPR and first aid certifications must be kept current;

(e) documentation of all training must include at least the following information: name of individual taking training, title of the training, source of instruction, number of hours of instruction, and date instruction was given;

(f) documentation of competency testing must include at least the following: name of individual being evaluated for competency, date and method used to determine competency, and copy of the attendant's graded and passed competency test in the attendant's personnel file; special accommodations must be made for attendants who are not able to read or write or who speak/read/write a language other than English;

(3) developing and maintaining a procedure to ensure trained and qualified attendants are available as backup for regularly scheduled attendants and emergency situations; complete instructions regarding the consumer's care and a list of attendant duties and responsibilities must be available in each consumer's home;

(4) informing the attendant of the risks of hepatitis B infection per current department of health (DOH) recommendation or the center for disease control and prevention (CDC), as appropriate, and offering hepatitis B immunization at the time of employment at no cost to the attendant; attendants are not considered to be at risk for hepatitis B since only non-medical services are performed; therefore, attendants may refuse the vaccine; documentation of the immunization, prior immunization, or refusal of immunization by the attendant must be in the attendant's personnel file;

(5) obtaining a copy of the attendant's current and valid state driver's license or other current and valid state photo id, if the consumer is to be transported by the attendant, obtaining a copy of the attendant's current and valid driver's license and current motor vehicle insurance policy; maintaining copies of these documents in the attendant's personnel file at all times;

(6) complying with federal and state regulations and labor laws;

(7) preparing all documentation necessary for payroll;

(8) complying with all specified medicaid participation requirements outlined in 8.302.1 NMAC, *General Provider Policies*;

(9) maintaining records that are sufficient to fully disclose the extent and nature of the services furnished to the consumers as outlined in 8.302.1 NMAC, *General Provider Policies*;

(a) the PCO agency may elect to keep a log/check-off list, in addition to the timesheet, in the consumer's home, describing services provided on a daily basis; if a log/check-off list is maintained, the log must be compared with the weekly timesheet and copies of both the timesheet and the log/check-off list must be kept in the consumer's file;

(b) the PCO agency may elect to use an electronic system that attendants may use to check in and check out at the end of each period of service delivery; the system must produce records that can be audited to determine the time of services provided, the type of services provided, and a verification by the consumer or the consumer's legal representative, as appropriate; failure by a PCO agency to maintain a proper record for audit under this system will subject the PCO agency to recovery by medicaid of any undocumented or insufficiently documented claims;

(10) obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCO services while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he/she will be immediately terminated;

(11) ensuring that if the consumer has elected the consumer's legal representative as his/her attendant, the agency has obtained prior approval from medicaid or its designee; all PCO services provided by the consumer's legal representative *MUST* be justified in writing by the agency and consumer and submitted for approval to medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and include a plan for oversight by the agency to assure service delivery; documentation of approval by medicaid or its designee must be maintained in the consumer's file; the agency must inform the consumer that if the consumer is appointed or selects a legal representative any time during the plan year, they must notify the agency immediately;

(12) establishing and explaining to all their consumers and all attendants the necessary documentation needed for reimbursement of PCO services;

(13) performing payroll activities for the attendants;

(14) providing state of New Mexico workers' compensation insurance for all attendants;

(15) conducting face-to-face supervisory visits in the consumer's residence at least once a month (12 per service plan year); each visit must be sufficiently documented in the consumer's file by indicating:

(a) date of visit;

(b) time visiting to include length of visit;

(c) name and title of person conducting supervisory visit;

(d) individuals present during visit;

(e) review of IPoC;

(f) identification of health and safety issues and quality of care provided by attendant, and

(g) signature of consumer or consumer's legal representative;

(16) maintaining an accessible and responsive 24-hour communication system for consumers to use in emergency situations to contact the agency;

(17) following current recommendations of DOH and CDC, as appropriate, for preventing the transmission of TB for attendants upon initial employment and as needed; and

(18) verifying initially prior to employment, and annually thereafter, that attendants are not on the employee abuse registry by researching COR pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA 1978, Section 27-7A-1 et seq.

[8.315.4.12 NMAC - Rp, 8.315.4.11 & 12 NMAC, 12-30-10; A, 9-15-11]

8.315.4.15 COVERAGE CRITERIA: PCO services have been established to assist individuals 21 years of age or older who are eligible for full medicaid benefits and meet the NF LOC criteria, see, *long term care services utilization review instructions for nursing facilities* which is attached to this part of the NMAC as attachment II. PCO services are defined as those tasks necessary to avoid institutionalization and maintain the consumer's functional level and independence. PCO services are for consumers who are unable to perform at least two ADLs because of disability or functional limitation and need assistance with certain ADLs and IADLs as described in Attachment II to this part of the NMAC. PCO services are allocated for a reasonable accommodation of tasks to be performed by a personal care attendant, but do not provide 24-hours per day services. A PCO service assessment conducted pursuant to 8.315.4.19 NMAC, *assessments for services*, determines the amount and type of services needed to supplement the services a consumer is already receiving including those services provided by natural supports. PCO services are not provided 24 hours a day and allocation of time and services must be [~~closely aligned with the~~] directly related to an individual's [~~impairment rating~~] functional level to perform ADLs and IADLs as indicated in the PCO service assessment and applied to the PCO service guide, MAD 055 [~~which~~]. The PCO service guide, MAD 055 is attached to this part of the NMAC as attachment I.

A. PCO services are

usually furnished in the consumer's place of residence, except as otherwise indicated, and during the hours specified in the consumer's IPoC. Services may be furnished outside the residence only when appropriate and necessary and when not available through other existing benefits and programs, such as home health or other state plan or long-term care services. If a consumer is receiving hospice care, is a resident in an assisted living facility, shelter home, or room and board facility, the TPA for FFS or the MCO for CoLTS, will perform an assessment and ensure that the PCO services do not duplicate the services that are already being provided. If ADL or IADL services are part of the hospice or assisted living facility, shelter home, or room and board facility, as indicated by the contract or admission agreement signed by the consumer, PCO services cannot duplicate those services. Regulations for assisted living facilities may be found at 7.8.2 NMAC, *Assisted Living Facilities for Adults.*

B. PCO services are not furnished to an individual who is an inpatient or resident of a hospital, NF, ICF/MR, mental health facility, correctional facility, other institutional settings (except for recipients of community transition goods or services).

C. All consumers, regardless of living arrangements, will be assessed for natural supports. PCO services are not intended to replace natural supports. Service hours will be allocated, as appropriate, to supplement the natural supports available to a consumer. Consumers that reside with other adult household members, that are not receiving PCO services or are not disabled, will be presumed to have household services in the common/shared areas provided by the other adult residents, whether or not the adult residents are the selected personal care attendant. Personal care attendants that live with the consumer will not be paid to deliver household services, support services (shopping and errands), or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., cleaning consumer's room, linens, clothing, and special diets). If a consumer's living situation changes:

(1) such that there is no longer a shared living space with another consumer, he/she will be re-assessed for services that were allocated between multiple consumers in a shared household; or

(2) such that he/she begins sharing a living space with another consumer(s), all consumers in the new shared living space will be re-assessed to determine the allocation of services shared by all consumers residing in the household.

[8.315.4.15 NMAC - Rp, 8.315.4.13 NMAC, 12-30-10; A, 9-15-11]

8.315.4.16 COVERED SERVICES: [~~PCO services are provided as described in Subsections A through J. Consumers will be assessed both individually and jointly if sharing a living space with another PCO applicant/recipient (Subsection K), in each of the following listed service categories. PCO services will not include those services for tasks the individual does not need or is already receiving from other sources including tasks provided by natural supports. PCO services must be related to the individual's impairment rating as indicated in the PCO Service Guide, MAD 055 which is attached to this part of the NMAC as attachment I.~~

~~A. **Individualized bowel and bladder services:** These services include bowel care, bladder care, perineal care and toileting.~~

~~(1) Pursuant to NMSA 1978, Section 61-3-29(J) of the Nursing Practice Act, bowel and bladder care may be provided to a consumer that is medically stable and able to communicate and assess his/her own needs to include:~~

~~(a) bowel care - evacuation and ostomy care, changing and cleaning of bags and ostomy site skin care; an individual requiring assistance with bowel care who does not have a statement by his/her physician determining he/she is medically stable and able to communicate his/her bladder care needs is not eligible for PCO services in this category; digital stimulation is not a covered service; and~~

~~(b) bladder care - cueing the consumer to empty his/her bladder at timed intervals to prevent incontinence; elimination; catheter care, including the changing and cleaning of the catheter bag; the requirements and limitations from Subparagraph (a) bowel care above regarding medically determined stability and ability to communicate apply here; insertion/extraction of a catheter is not a covered service.~~

~~(2) Services that do not require the consumer to be medically stable and able to communicate and assess his/her own needs include:~~

~~(a) perineal care - cleansing of the perineal area and changing of sanitary napkins; and~~

~~(b) toileting - assisting with bedside commode or bedpan; cleaning perineal area, changing adult briefs/pads, readjusting clothing; cleaning changing of wet or soiled clothing after incontinence episodes or assisting with adjustment of clothing before and after toileting.~~

~~B. **Meal preparation and assistance:** At the direction of the consumer or his/her personal representative, prepare meal(s) including cutting ingredients to be cooked, cooking of meals, and placing/presenting meal in front of consumer to eat, and cutting up food into bite-sized portions for the consumer or assist the consumer pursuant to the IPoC. This includes provision of snacks and fluids and may include cueing and prompting the consumer to prepare meals. This does not include assistance with eating. Services requiring assistance with eating are covered under eating in Subsection G below. Personal care attendants who reside in the same household as the consumer may not be paid for meal preparation routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., special diets, processing of meals into edible portions, pureeing).~~

~~C. **Support services:** These are services that provide additional assistance to the consumer. Personal care attendants who reside in the household may not be paid for shopping or errands routinely provided as part of the household division of chores, unless those services are specific to the consumer. These services are limited to:~~

~~(1) shopping or completing errands specific to the consumer (with or without the consumer);~~

~~(2) transportation of the consumer - transportation shall only be for non-medically necessary events and may include assistance with transfers in/out of vehicles; PCO agencies are not required to provide this service; consumers that need this service and are with a PCO agency that does not provide this service may transfer to a different PCO agency in accordance with 8.315.4.22 NMAC, *transfer process for PCO services;* medically necessary transportation services may be a covered PCO service when the TPA for FFS or the MCO for CoLTS has assessed and determined that other medically necessary transportation services are not available through other state plan services; and~~

~~(3) assistance with feeding and hydrating or cueing consumer to feed and hydrate a personal assistance animal for the consumer is a covered service; a consumer must provide documentation that his/her animal is a personal assistance animal; feeding and hydrating non-assistance animals is not a covered service.~~

~~D. **Hygiene/grooming:** The IPoC may include the following tasks to be performed by the attendant or cueing and prompting by the attendant for the consumer to perform the tasks. These services include:~~

~~(1) bathing - giving a sponge bath/bed bath/tub bath/shower, including transfer in/out, turning bath/shower water off/on, and setting temperature of bath/shower water; bringing in water from outside or heating water for consumer;~~

~~(2) dressing - putting on, fastening, removing clothing, and shoes;~~

~~(3) grooming - combing or~~

brushing hair, applying make-up, trimming beard or mustache, braiding hair, shaving under arms, legs or face;

(4) oral care with intact swallowing reflex - brushing teeth, cleaning dentures/ partials (includes use of floss, swabs, or mouthwash);

(5) nail care - cleaning, filing to trim, or cuticle care, except for consumers with a medical condition such as venous insufficiency, diabetes, peripheral neuropathy, or consumers that are documented as medically at risk, which then would be considered a skilled task and not a covered PCO service;

(6) applying lotion to intact skin for routine skin care; and

(7) cueing to ensure appropriate bathing, dressing, grooming, oral care, nail care and application of lotion for routine skin care.

E. **Minor maintenance of assistive device(s):** Battery replacement and minor, routine wheelchair and durable medical equipment (DME) maintenance or cleaning is a covered service. A consumer must have an assistive device(s) that requires regular cleaning or maintenance (that is not already provided by the supplier of the assistive device) that the consumer cannot clean and maintain to be eligible to receive services under this category.

F. **Mobility assistance:** Either physical assistance or verbal prompting and cueing provided by the attendant is a covered service. These include assistance with:

(1) ambulation - moving around inside or outside the residence or consumer's living area with or without assistive device(s) such as walkers, canes and wheelchairs;

(2) transferring - moving to/from one location/position to another with or without assistive devices(s) including in and out of vehicles;

(3) toileting - transferring on/off toilet; and

(4) repositioning - turning or moving an individual to another position who is bed bound to prevent skin breakdown.

G. **Eating:** Feeding the consumer or assisting the consumer with eating a prepared meal with a utensil or with specialized utensils is a covered service. Eating is the ability to physically put food into mouth, chew and swallow food safely. The attendant shall assist the consumer as determined by the IPoC. Eating assistance may include cueing a consumer to ensure appropriate nutritional intake or monitor for choking. This does not include preparation of food/meals. Services requiring preparation of food/meals is covered under meal preparation and assistance in Subsection B. If the consumer has special needs in this area, the attendant should receive specific instruction to meet that need. Gastrostomy feeding and tube feeding are not covered services.

H. **Assisting with self-administered medication:** This service is limited to *prompting and reminding only* for self-administering physician ordered (prescription) medications. The use of over the counter medications does not qualify for this service. The ability to self-administer is defined as the ability to identify and communicate medication name, dosage, frequency and reason for the medication. A consumer who does not meet this definition of ability to self-administer is not eligible for this service. This assistance does not include administration of injections, which is a skilled/nursing task. Splitting or crushing medication or filling of medication boxes is not a covered service. Assistance includes:

(1) getting a glass of water or other liquid as requested by the consumer for the purpose of taking medications;

(2) at the direction of the consumer handing the consumer his/her daily medication box or medication bottle;

(3) at the direction of the consumer, helping a consumer with placement of oxygen tubes for consumers who can communicate to the caregiver the dosage/route of oxygen;

(4) splitting or crushing medication or filling of medication boxes is not a covered service.

I. **Skin care:** The consumer must have a skin disorder documented by a physician, physician assistant, nurse practitioner or a clinical nurse specialist to be eligible to receive skin care services. This service is limited to the attendant's application of over-the counter or prescription skin cream for a diagnosed chronic skin condition that is not related to burns, pressure sores or ulceration of skin. A consumer must meet the definition of "ability to self-administer" defined in Subsection H of this section, to be eligible to receive time for application of a prescription over the counter medication for skin care. Wound care/open sores and debriding/dressing open wounds are not covered services.

J. **Household services:** This service is for performing interior household activities as needed. Such activities are limited to the maintenance of the consumer's personal living area (i.e., kitchen, living room, bedroom, and bathroom). To maintain a clean and safe environment for the consumer, particularly a consumer living alone who may not have adequate support in his/her residence. Personal care attendants who reside in the same household as the consumer may not be paid for this service routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., changing the consumer's linens, cleaning the consumer's personal living areas). Services include:

(1) sweeping, mopping or vacuuming the consumer's carpets, hardwood floors, tile or linoleum;

(2) dusting the consumer's furniture;

(3) changing the consumer's linens;

(4) washing the consumer's laundry;

(5) cleaning the consumer's bathroom (tub or shower area, sink, and toilet);

(6) cleaning the consumer's kitchen and dining area (i.e., washing the consumer's dishes, putting the consumer's dishes away; cleaning counter tops, cleaning the area where the consumer eats, etc.); household services do not include cleaning up after other household members or pets.

K. **Shared households/ living space:** Two or more consumers living in the same residence, (including assisted living facilities, shelter homes, and other similar living arrangements), who are receiving PCO services will be assessed both individually and jointly to determine services that are shared. Consumers sharing living space will be assessed as follows for services identified in Subsections B, C and J of 8.315.4.16 NMAC:

(1) individually to determine if the consumer requires unique assistance with the service; and

(2) jointly with other household members to determine shared living space and common needs of the household; services will be allocated based on common needs, not based on individual needs, unless it has been assessed by the TPA for FFS or the MCO for CoLTS, there is an individual need for provision of the service(s); (common needs may include meals that can be prepared for several individuals; shopping/errands that can be completed at the same time; laundry that can be completed for more than one individual at the same time; dusting and vacuuming of shared living spaces), these PCO services are based on the assessment of combined needs in the household without replacing natural and unpaid supports identified during the assessment.**]** PCO services are provided as described in Paragraphs (1) through (6) of Subsection D. PCO services will not include those services for tasks the individual does not need or is already receiving from other sources including tasks provided by natural supports. PCO services must be related to the individual's functional level to perform ADLs and IADLs as indicated in the PCO service assessment conducted pursuant to 8.315.4.19 NMAC, *assessments for services*, and applied to the PCO service guide, MAD 055. See attachment I.

A. Mobility assistance, either physical assistance or verbal

prompting and cueing, may be provided during the administration of any PCO task by the attendant. Mobility assistance includes assistance with ambulation, transferring and repositioning which is defined as moving around inside or outside the residence or consumer's living area with or without assistive devices(s) such as walkers, canes and wheelchairs or turning or moving to another position to prevent skin breakdown.

B. Certain PCO services are provided only when the consumer has the ability to self-administer. Ability to self-administer is defined as the ability to identify and communicate medication name, dosage, frequency and reason for the medication. A consumer who does not meet this definition of ability to self-administer is not eligible for these services.

C. When two or more consumers living in the same residence (including assisted living facilities, shelter homes, and other similar living arrangements), are receiving PCO services, they will be assessed both individually and jointly to determine services that are shared. Consumers sharing living space will be assessed for services identified in Paragraphs (2) and (4) of Subsection D of 8.315.4.16 NMAC: assess each consumer individually to determine if the consumer requires unique assistance with the service; and jointly with other household members to determine shared living space and common needs of the household; services will be allocated based on common needs, not based on individual needs, unless assessed by the TPA for FFS or the MCO for CoLTS that there is an individual need for provision of the service(s) as indicated above; (common needs may include meals that can be prepared for several individuals; shopping/errands that can be completed at the same time; laundry that can be completed for more than one individual at the same time; dusting and vacuuming of shared living spaces); these PCO services are based on the assessment of combined needs in the household without replacing natural and unpaid supports identified during the assessment.

D. Description of PCO services.

(1) **Individualized bowel and bladder services:** These services include bowel care, bladder care, perineal care and toileting.

(a) Pursuant to NMSA 1978, Section 61-3-29(J) of the Nursing Practice Act, bowel and bladder care may be provided to a consumer that is medically stable and able to communicate and assess his/her own needs to include:

(i) bowel care - evacuation and ostomy care, changing and cleaning of bags and ostomy site skin care; an individual requiring assistance with bowel care who does not have a statement by his/her physician determining he/she is medically stable and able to communicate his/her bladder care needs is not eligible for PCO services in this category; digital stimulation is not a covered service; and

(ii) bladder care - cueing the consumer to empty his/her bladder at timed intervals to prevent incontinence; elimination; catheter care, including the changing and cleaning of the catheter bag; the requirements and limitations from Item (i) bowel care above regarding medically determined stability and ability to communicate apply here; insertion/extraction of a catheter is not a covered service.

(b) Services that do not require the consumer to be medically stable and able to communicate and assess his/her own needs include:

(i) perineal care - cleansing of the perineal area and changing of sanitary napkins; and

(ii) toileting - assisting with bedside commode or bedpan; cleaning perineal area, changing adult briefs/pads, readjusting clothing; cleaning changing of wet or soiled clothing after incontinence episodes or assisting with adjustment of clothing before and after toileting;

(c) mobility assistance to ensure appropriate bowel and bladder services.

(2) **Meal preparation and assistance:** At the direction of the consumer or his/her personal representative, prepare meal(s) including cutting ingredients to be cooked, cooking of meals, and placing/presenting meal in front of consumer to eat, and cutting up food into bite-sized portions for the consumer or assist the consumer pursuant to the IPoC. This includes provision of snacks and fluids and may include mobility assistance and prompting/cueing the consumer to prepare meals. This does not include assistance with eating. Services requiring assistance with eating are covered under eating in Paragraph (3) below. Personal care attendants who reside in the same household as the consumer may not be paid for meal preparation routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., special diets, processing of meals into edible portions, pureeing).

(3) **Eating:** Feeding the consumer or assisting the consumer with eating a prepared meal with a utensil or with specialized utensils is a covered service. Eating is the ability to physically put food into mouth, chew and swallow food safely. The attendant shall assist the consumer as determined by the IPoC. Eating assistance may include mobility assistance and prompting/cueing a consumer to ensure appropriate nutritional intake or monitor for choking. This does not include preparation of food/meals. Services requiring preparation of food/meals is covered under meal preparation and assistance in Paragraph (2). If the consumer has special needs in this area, the attendant should receive specific instruction to meet that need. Gastrostomy feeding and tube feeding are not covered services.

(4) **Household support services:** This service is for assisting/performing interior household activities as needed and other support services that provide additional assistance to the consumer. Interior household activities are limited to the maintenance of the consumer's personal living area (i.e., kitchen, living room, bedroom, and bathroom). To maintain a clean and safe environment for the consumer, particularly a consumer living alone who may not have adequate support in his/her residence. Assistance may include mobility assistance and prompting/cueing a consumer to ensure appropriate household support services. Personal care attendants who reside in the same household as the consumer may not be paid for household support services routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., changing the consumer's linens, cleaning the consumer's personal living areas). Services include:

(a) sweeping, mopping or vacuuming the consumer's carpets, hardwood floors, tile or linoleum;

(b) dusting the consumer's furniture;

(c) changing the consumer's linens;

(d) washing the consumer's laundry;

(e) cleaning the consumer's bathroom (tub or shower area, sink, and toilet);

(f) cleaning the consumer's kitchen and dining area (i.e., washing the consumer's dishes, putting the consumer's dishes away; cleaning counter tops, cleaning the area where the consumer eats, etc.); household services do not include cleaning up after other household members or pets;

(g) minor cleaning of assistive device(s), wheelchair and durable medical equipment (DME) is a covered service; a consumer must have an assistive device(s) that requires regular cleaning (that is not already provided by the supplier of the assistive device) that the consumer cannot clean to be eligible to receive services under this category;

(h) shopping or completing errands specific to the consumer (with or without the consumer);

(i) transportation of the consumer - transportation shall only be for non-medically necessary events and may include assistance with transfers in/out of vehicles; PCO agencies are not required to provide this service; consumers that need this service and

are with a PCO agency that does not provide this service may transfer to a different PCO agency in accordance with 8.315.4.22 NMAC, *transfer process for PCO services;* medically necessary transportation services may be a covered PCO service when the TPA for FFS or the MCO for CoLTS has assessed and determined that other medically necessary transportation services are not available through other state plan services;

(j) assistance with feeding and hydrating or cueing consumer to feed and hydrate a personal assistance animal for the consumer is a covered service; a consumer must provide documentation that his/her animal is a personal assistance animal; feeding and hydrating non-assistance animals is not a covered service;

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

(l) assistance with self-administering physician ordered (prescription) medications is limited to *prompting and reminding only*; the use of over the counter medications does not qualify for this service; a consumer must meet the definition of "ability to self-administer" defined in this section, to be eligible to receive time for this task; a consumer who does not meet the definition of ability to self-administer is not eligible for this service; this assistance does not include administration of injections, which is a skilled/nursing task; splitting or crushing medications or filling medication boxes is not a covered service; assistance includes:

(i) getting a glass of water or other liquid as requested by the consumer for the purpose of taking medications;

(ii) at the direction of the consumer, handing the consumer his/her daily medication box or medication bottle; and

(iii) at the direction of the consumer, helping a consumer with placement of oxygen tubes for consumers who can communicate to the caregiver the dosage/route of oxygen.

(5) **Hygiene/grooming:** The IPoC may include the following tasks to be performed by the attendant or cueing and prompting by the attendant for the consumer to perform the tasks. These services include:

(a) bathing - giving a sponge bath/bed bath/tub bath/shower, including transfer in/out, turning bath/shower water off/on, and setting temperature of bath/shower water; bringing in water from outside or heating water for consumer;

(b) dressing - putting on, fastening, removing clothing, and shoes;

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

(d) oral care with intact swallowing reflex - brushing teeth, cleaning dentures/partials (includes use of floss, swabs, or mouthwash);

(e) nail care - cleaning, filing to trim, or cuticle care, except for consumers with a medical condition such as venous insufficiency, diabetes, peripheral neuropathy, or consumers that are documented as medically at risk, which then would be considered a skilled task and not a covered PCO service;

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

(g) physician ordered skin care – the consumer must have a skin disorder documented by a physician, physician assistant, nurse practitioner or a clinical nurse specialist to be eligible to receive skin care services; this service is limited to the attendant's application of over-the counter or prescription skin cream for a diagnosed chronic skin condition that is not related to burns, pressure sores or ulceration of skin; a consumer must meet the definition of "ability to self-administer" defined in this section, to be eligible to receive time for application of a prescription over-the counter medication for skin care; wound care/open sores and debriding/dressing open wounds are not covered services;

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

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

(6) **Supportive mobility assistance:** Physical or verbal prompting and cueing mobility assistance provided by the attendant that are not already included as part of other PCO service tasks. These include assistance with:

(a) ambulation - moving around inside or outside the residence or consumer's living area with or without assistive device(s) such as walkers, canes and wheelchairs;

(b) transferring - moving to/from one location/position to another with or without assistive devices(s) including in and out of vehicles;

(c) toileting - transferring on/off toilet; and

(d) repositioning - turning or moving an individual to another position who is bed bound to prevent skin breakdown.

[8.315.4.16 NMAC - Rp, 8.315.4.14 NMAC, 12-30-10; A, 9-15-11]

8.315.4.18 MEDICAL ELIGIBILITY: To be eligible for PCO services, a consumer must meet the LOC required in a NF.

A. The TPA is responsible for making LOC determinations based on criteria developed by medicaid or medicaid's designee according to national standards. See attachment II to this part titled *long term care services utilization review instructions for nursing facilities*.

(1) **Determine level of care (LOC):** The TPA makes initial LOC determinations and subsequent determinations at least annually thereafter.

(a) An LOC packet is developed by the TPA for FFS and the MCO for CoLTS and reviewed by the TPA to determine approval for medical eligibility.

(b) The LOC packet must include:

(i) a current (within the last six months) approved medical assessment form [~~(ISD 379)~~] (MAD 379) signed by a physician or physician's designee (physician assistant, nurse practitioner or, clinical nurse specialist);

(ii) a current H&P: a H&P is current when the date of service is not more than 12 months from the date the medical provider completed the MAD 379 medical assessment form; documentation of the H&P is any documentation that is consistent with a reimbursable medicare/medicaid H&P provider claim; this includes documentation of the evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations(s), laboratory/diagnostic procedures;

[~~(ii)~~] (iii) any other information or medical justification documenting the consumer's functional abilities; and

[~~(iii)~~] (iv) an assessment of the consumer's functional needs, performed by the TPA initially through the in-home assessment (MAD 057), or for subsequent approval, subsequent assessments performed by the TPA for FFS or MCO for CoLTS; for subsequent assessments, a current in-home assessment is one that is completed after a renewal notice is issued to a consumer and prior to the end of the annual LOC date span.

(2) **The TPA will use the LOC packet to:**

(a) make all LOC determinations for all consumers requesting/receiving PCO services;

(b) approve the consumer's LOC for a maximum of one year (12 consecutive months); and a new LOC determination must be made at least annually to ensure the consumer continues to meet medical eligibility criteria for PCO services; each

LOC determination must be based on the consumer's current medical condition and need of service(s) and may not be based on prior year LOC determinations; the approved NF LOC has a start date and an end date of no more than 12 consecutive months, which is the NF LOC span; and

(c) contact the consumer for FFS or the MCO for CoLTS within a minimum of 120 days, prior to the expiration of the approved LOC, to begin the annual LOC review process for PCO services to prevent a break in service; the TPA for FFS or the MCO for CoLTS shall also provide a notification to the PCO agency, at the same time the consumer is notified, that the LOC is due to expire within 120 days.

(3) Any individual applying for PCO services who has an existing approved NF LOC in another program (i.e., CoLTS (c) waiver or nursing facility) will not need another LOC determination until his/her next annual NF LOC assessment.

B. **Initial in-home assessment:** The TPA must perform an initial in-home assessment (MAD 057) of the consumer's functional needs in the consumer's place of residence. The initial in-home assessment is only done one time by the TPA when the consumer is first evaluated for eligibility for PCO services and not upon annual renewal.

C. The TPA must initially explain both service delivery models, consumer-directed and consumer-delegated to the consumer or his/her legal representative and provide the consumer or his/her legal representative with informational material, allowing the consumer to make the best educated decision possible regarding which model he/she will select. A copy of the consumer's or legal representative's responsibilities in 8.315.4.10 NMAC, *service delivery models*, must be provided to each consumer or legal representative. If the consumer is FFS, the TPA must explain both service delivery models and provide a copy of the consumer's responsibilities in 8.315.4.10 NMAC, *service delivery models*, at every annual assessment, based on the service delivery model he/she has selected.

D. A PCO agency that does not agree with the LOC determination made by the TPA or medicaid's designee may work with the consumer's physician or physician designee that submitted the [~~ISD 379~~] MAD 379 form [~~or, for CoLTS consumers, with the MCO~~] to request a re-review or reconsideration from the TPA pursuant to medicaid oversight policies, 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

E. A consumer that does not agree with the LOC determination made by the TPA may file a grievance with the TPA, or request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings*, or request both.

F. Conflict of interest: The TPA is not authorized to contract with any medicaid approved PCO agency to carry out TPA responsibilities or any person, agency, or entity that would have any other actual or potential conflict of interest as a TPA subcontractor due to its financial or corporate relationship or relationship by blood (consanguinity) or by affinity (by marriage) to the third degree with a PCO personal care provider agency or its principals. A conflict of interest includes the situation in which a principal or a relative of the principal of the prospective TPA contracting entity has a financial interest in a PCO provider agency.

G. Temporary authorization: If the consumer is determined to meet the medical eligibility criteria to receive PCO services, but is not yet enrolled in CoLTS, the TPA automatically gives these consumers a temporary prior-authorization of 10 hours per week for up to 75 days. This temporary prior-authorization is automatic for all CoLTS consumers that are medically eligible and is not a determination of a CoLTS consumer's actual need. The consumer's actual need may be higher or lower as determined by the assessment for services performed by the MCO for CoLTS. There is no right to a fair hearing with respect to this temporary prior authorization. The approval for 10 hours is not a guarantee of a minimum amount of services when the consumer is assessed by the MCO for CoLTS for need of services. Temporary prior authorization of services does not guarantee that an individual is eligible for medicaid. PCO agencies must verify monthly all individuals' financial eligibility for medicaid prior to providing services. FFS consumers do not receive a temporary authorization as their assessment of services is conducted at the same time as the LOC assessment.

H. The TPA shall review the LOC upon a referral from the PCO agency, the consumer the consumer's legal representative, or the MCO for CoLTS regarding an improvement or decline in the consumer's health condition and make a new determination regarding eligibility, as appropriate.

I. The [~~ISD 379~~] completed MAD 379 form and H&P is used solely to determine the LOC and is not used to determine the type or the amount of PCO services for a consumer. The MAD 057 is used [~~solely~~] to obtain initial [~~LOC~~] in-home assessment information on a consumer who is FFS or not yet enrolled in CoLTS.

[8.315.4.18 NMAC - N, 12-30-10; A, 9-15-11]

8.315.4.19 ASSESSMENTS FOR SERVICES: After the consumer is determined to be medically eligible for PCO services, the TPA for FFS or the MCO for CoLTS performs [~~an~~] a PCO service assessment [~~to include the personal care options (MAD 055) of the consumer's natural supports and need of covered services~~] (assessment form approved by the state). Although an individual's assessment for the amount and types of services may vary, PCO services are not provided 24 hours a day. An individual's PCO services must be directly related to their functional level to perform ADLs and IADLs as indicated in the PCO service assessment and applied to the separate PCO service guide, MAD 055. The PCO service guide, MAD 055, is attached to this part of the NMAC as attachment I. Service assessments are performed when a consumer enters the program (initial assessment), at least annually (annual assessment) or in the interim (interim assessment) if certain criteria are met.

A. The service assessment (initial, interim, or annual) performed by the TPA for FFS or the MCO for CoLTS determines the type of covered services needed by the consumer. [~~(assessment form approved by the state) and~~] The amount of time allocated to each type of covered service [~~(recorded on the MAD 055)~~] is determined by applying and recording the individual's functional level to perform ADLs and IADLs from the service assessment, to the separate PCO service guide, MAD 055. PCO services are allocated for a reasonable accommodation of tasks to be performed by a personal care attendant[~~, but do not provide 24-hour per day services~~]. A PCO service assessment determines the amount and type of PCO services needed to supplement and not duplicate the services a consumer is already receiving including those services provided by natural supports. [~~The PCO service guide, the MAD 055, which is attached to this part of the NMAC as attachment I is used as a tool to record service assessment responses that determine the type of PCO services that are needed and the time allotted for each PCO service as it relates to the individual's impairment ratings.~~] In the [~~rare~~] event that the consumer's functional needs exceed the average allocation of time allotted to perform a particular service task per the recommendation of a medical professional, the TPA for FFS or the MCO for CoLTS may consider authorizing additional time based on the consumer's verified medical and clinical need(s).

B. The service assessment and MAD 055 is conducted and discussed with the consumer in the consumer's place of residence by the TPA for FFS or the MCO for CoLTS and shall be based on the current health condition and functional needs of the consumer, to include no duplication of services a consumer is already receiving including those services provided by natural supports, and shall not be based on a prior assessment of the consumer's health

condition, functional needs, or existing services.

C. The completed service assessment and MAD 055 is sent to the PCO agency by the TPA for FFS or the MCO for CoLTS for the PCO agency to develop the IPoC.

D. The assessment must be performed by the TPA for FFS or the MCO for CoLTS upon a consumer's initial approval for medical NF LOC eligibility to receive PCO services (initial assessment) and at least annually thereafter (annual assessment). The annual assessment is completed prior to the expiration of the current NF LOC span and determines the type and amount of services for the subsequent NF LOC span. The type and amount of PCO services as determined by an annual assessment shall not be effective prior to the start of the applicable NF LOC span. The TPA for FFS or the MCO for CoLTS must complete an assessment within 75 days from the date of the temporary prior authorization. [~~The assessment may be performed more often than annually.~~] An interim assessment may be conducted if:

(1) there is a change in the consumer's condition (either improved or declined);

(2) there is a change in the consumer's natural supports or living conditions;

(3) upon the consumer's request;

(4) the full amount of services has not been utilized within the last two months; or

(5) upon a referral from a PCO agency regarding the consumer's need for an assessment.

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

F. [~~Consumers enrolled in a CoLTS MCO who disagree with authorized number of hours may utilize the CoLTS MCO grievance and appeal process, request a fair hearing, or both.~~] The TPA for FFS or the MCO for CoLTS will issue a prior authorization (PA) to the PCO agency. A PCO service authorization cannot extend beyond the LOC span and must be provided to the PCO agency prior to the PA effective date and not applied retroactively.

G. A PCO consumer who disagrees with the authorized number of hours may utilize the CoLTS MCO grievance and appeal process when enrolled in CoLTS and the state's fair hearing process pursuant to 8.352.2 NMAC, *Recipient Hearings*, or both. Requests for an MCO grievance/appeal and a state fair hearing may be filed consecutively or concurrently so long as each request is within the required time limitations for making such a request. The TPA for FFS or the MCO for CoLTS may schedule a pre-hearing conference with the consumer to explain how the PCO regulations were applied to the authorized service time and to attempt to resolve disagreements prior to the fair hearing.

(1) Continuation of benefits: A consumer may continue PCO benefits while an MCO grievance and appeal or state's fair hearing decisions are pending, pursuant to 8.352.2 NMAC, *Recipient Hearings*, if the member requests continuation of benefits within 13 calendar days of the date of the notice of action.

(2) The consumer may be responsible for repayment of the cost of the services furnished while the MCO grievance and appeal process or the state's fair hearing process was pending, to the extent that the services were furnished solely because of this requirement to provide continuation of benefits during the MCO grievance and appeal or state fair hearing process. The state for FFS or the MCO for CoLTS may recover these costs from the member and not the provider.

[8.315.4.19 NMAC - N, 12-30-10; A, 9-15-11]

8.315.4.20 INDIVIDUAL PLAN OF CARE (IPOC): [~~An IPoC is developed and PCO services are identified along with the appropriate assessment for allocating PCO services. The PCO agency develops an IPoC using an authorization, task list and the MAD 055 provided by the TPA for FFS or the MCO for CoLTS. The finalized IPoC contains approved daily tasks, for a period of seven days at a time, to be performed by the attendant based on the consumer's daily needs. Only those services identified as IADLs (household services, certain support services (shopping and errands) or meal preparation) may be moved to another day within a seven-day IPoC. Any tasks not performed by the attendant for any reason cannot be banked or saved for a later date.~~] An IPoC is developed and PCO services are identified along with the appropriate assessment for allocating PCO services. The PCO agency develops an IPoC using an MCO authorization, service assessment and the MAD 055 provided by the TPA for FFS or the MCO for CoLTS. The finalized IPoC must contain a seven-day schedule including the identification and documentation of natural support days not authorized for PCO services and authorized PCO attendant task days and tasks to be performed by the PCO caregiver. Only those services identified as IADLs, household support services or certain ADL PCO services such as meal preparation may be moved to another day, using the IPoC as a tool. The PCO agency must document more and less service time on the IPoC for specific day(s) during the week as long as the consumer has his/her daily needs met and the total weekly hours do not exceed the weekly task total. Consumers receiving services only a certain number of days of the week may not be allocated time for ADLs on days in which an attendant does not provide services, i.e., time will not be allocated for ADLs for seven days if a consumer receives services only four days during the week. Any tasks not performed by the attendant for any reason cannot be banked or saved for a later date.

A. The PCO agency must:

(1) develop the IPoC with a specific description of the attendant's responsibilities, including tasks to be performed by the attendant and any special instructions related to maintaining the health and safety of the consumer;

(2) ensure the consumer has participated in the development of the plan and that the IPoC is reviewed and signed by the consumer or the consumer's legal representative; a signature on the IPoC indicates that the consumer or the consumer's legal representative understands what services have been identified and that services will be provided on a weekly basis for a maximum of one year; if a consumer is unable to sign the IPoC and the consumer does not have a legal representative, a thumbprint or personal mark (i.e., an "X") will suffice; if signed by a legal representative, medicaid or its designee and the agency must have documentation in the consumer's file verifying the individual is the consumer's legal representative;

(3) maintain an approved IPoC for PCO services for a maximum of one year (12 consecutive months), a new IPoC must be developed at least annually, to ensure the consumer's current needs are being met; a consumer's previous year IPoC is not used or considered in developing a new IPoC and allocating services; a new IPoC must be developed independently at least every year based on the consumer's current medical condition and need of services; the tasks and number of hours in the IPoC must match the authorized tasks and number of hours on the authorization;

(4) provide the consumer and the TPA for FFS or MCO for CoLTS with a copy of their approved IPoC;

(5) obtain an approved task list and MAD 055 from the TPA for FFS or MCO for CoLTS;

(6) obtain written verification that the consumer or the consumer's legal representative understands that if the consumer does not utilize services (for two months) or the full amount of allocated services (within a two-month period) on the IPoC that these circumstances will be documented in the consumer's file for need of services; and

(7) submit a personal care transfer/closure form (MAD 062 or other approved transfer/closure form) to the TPA for FFS or MCO for CoLTS for a consumer who

has passed away or who has not received services for 90-consecutive days.

B. PCO services are to be delivered in the state of New Mexico only. Consumers who require PCO services out of the state, for medically necessary reasons only, must obtain medicaid or medicaid's designee for FFS or the MCO for CoLTS written approval prior to leaving the state. The following must be submitted for consideration when requesting medically necessary out-of-state services:

(1) a letter from the consumer or the consumer's legal representative requesting an out-of-state exception and reason for request; the letter must include:

(a) the consumer's name and social security number;

(b) how time sheets/logs/check-off list will be transmitted and payroll checks issued to the attendant;

(c) date the consumer will be leaving the state, including the date of the medical procedure or other medical event, and anticipated date of return; and

(d) where the consumer will be housed after the medical procedure;

(2) a letter or documentation from the physician, surgeon, physician assistant, nurse practitioner, or clinical nurse specialist verifying the date of the medical procedure; and

(3) a copy of the consumer's approved IPoC and a proposed adjusted revision of services to be provided during the time the consumer is out-of-state; support services and household services will not be approved unless justified; if the consumer has been approved for services under self-administered medications, a statement from the physician, physician assistant, nurse practitioner, or clinical nurse specialist must be included indicating the consumer will continue to have the ability to self-administer for the duration he/she is out-of-state.

[8.315.4.20 NMAC - Rp, 8.315.4.17 NMAC, 12-30-10; A, 9-15-11]

8.315.4.22 TRANSFER PROCESS FOR PCO SERVICES: A consumer wishing to transfer services to another medicaid approved PCO agency may request to do so. Transfers within the plan year may be requested by the consumer, but must be approved by medicaid or medicaid's designee prior to the agency providing PCO services to the consumer. All requests for change of service model (from directed/delegated) must be approved by the TPA for FFS or MCO for CoLTS prior to the receiving agency providing services to the consumer. Transfers may only be initiated by the consumer or his/her legal representative and may not be requested by the attendant as a result of an employment issue. For consumers enrolled in a CoLTS MCO, the transfer process is determined by medicaid or medicaid's designee and should be initiated by the consumer through the consumer's assigned service coordinator. The consumer must give the reason for the requested transfer.

A. A transfer requested by a consumer may be denied by medicaid or its designee for the following reasons:

(1) the consumer is requesting more hours/services;

(2) the consumer's attendant or family member is requesting the transfer;

(3) the consumer has requested three or more transfers within a six-month period;

(4) the consumer wants his/her legal guardian, spouse or attorney-in-fact to be his/her attendant;

(5) the consumer wants an individual to be his/her attendant who has not successfully passed a nationwide criminal history screening;

(6) the consumer wants an attendant who has been terminated from another agency for fraudulent activities or other misconduct;

(7) the attendant does not want to complete the mandated trainings under the consumer-delegated model;

(8) the consumer does not wish to comply with the medicaid or PCO regulations and procedures; and

(9) there is reason to believe that solicitation has occurred as defined in 8.315.4.24 NMAC, *reimbursement.*

B. The TPA for FFS or MCO for CoLTS will notify the consumer and both the originating agency and the receiving agency of its decision and has 15-working days after receiving the request from the TPA to make a decision. The consumer must work with the TPA for FFS or the MCO for CoLTS to verify his/her request.

C. A consumer who does not agree with the decision may request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings*. The originating agency is responsible for the continuance of PCO services as identified in Subsection G of 8.315.4.19 NMAC throughout the fair hearing process.

D. The following is the process for submitting a transfer request.

(1) The consumer must inform the TPA for FFS or the MCO for CoLTS of the desire to transfer PCO agencies; the TPA for FFS or the MCO for CoLTS approves or denies the transfer request; if approved, the TPA for FFS or the MCO for CoLTS works with both the agency he/she is currently receiving services from (originating agency) and the agency he/she would like to transfer to (receiving agency) to effectively complete the transfer.

(2) Originating agencies are responsible for continuing service provision until the transfer is complete.

(3) Both the originating and receiving PCO agencies are responsible for following approved transfer procedures (either TPA for FFS or MCO for CoLTS transfer procedures).

(4) After the TPA for FFS or the MCO for CoLTS verifies the consumer's request, the TPA for FFS or the MCO for CoLTS will process the transfer request within 15 working days of receiving the transfer request.

(5) The TPA for FFS or the MCO for CoLTS will issue a new prior authorization number and task information to the receiving agency and make the transfer date effective 10 business days from the date of processing the transfer request with new dates of service and units remaining for the remainder of the IPoC year; the TPA for FFS or the MCO for CoLTS will notify the consumer and the originating and receiving PCO agencies.

[8.315.4.22 NMAC - Rp, 8.315.4.19 NMAC, 12-30-10; A, 9-15-11]

8.315.4.23 CONSUMER DISCHARGE: A consumer may be discharged from a PCO agency or may be discharged by the state from receiving any PCO services.

A. **PCO agency discharge:** The PCO agency may discharge a consumer for a justifiable reason. Prior to initiating discharge, the PCO agency must send a notice to medicaid or its designee for approval. Once approved by medicaid or its designee, the PCO agency may initiate the discharge process by means of a 30-day written notice to the consumer. The notice must include the consumer's right to request a fair hearing [~~and~~] pursuant to 8.352.2 NMAC, *Recipient Hearings*. The notice must include the justifiable reason for the agency's decision to discharge.

(1) A PCO agency may discharge a consumer for a justifiable reason. A justifiable reason for discharge may include:

(a) staffing problems (i.e., excessive request for change in attendants (three or more in a 30-day period);

(b) a consumer demonstrates a pattern of verbal or physical abuse toward attendants or agency personnel, including the use of vulgar or explicit (i.e. sexually) language, sexual harassment, excessive use of force, use of verbal threats or physical threats, demonstrates intimidating behavior; the agency or attendant must have documentation demonstrating the pattern of abuse; the agency may also discharge a consumer if the life of an attendant or agency's staff member is believed to be in immediate danger;

(c) a consumer or family member demonstrates a pattern of uncooperative behavior including not complying with

agency or medicaid regulations; not allowing the PCO agency to enter the home to provide services; and continued requests to provide services not approved on the IPoC;

(d) illegal use of narcotics or alcohol abuse; and

(e) fraudulent submission of timesheets; or

(f) living conditions or environment that may pose a health or safety risk or cause harm to the personal care attendant, employee of an agency, TPA, MCO, or other medicaid designee.

(2) The PCO agency must provide the consumer with a current list of medicaid-approved personal care agencies that service the county in which the consumer resides. The PCO agency must assist the consumer in the transfer process and must continue services throughout the transfer process. If the consumer does not select another PCO agency within the 30-day time frame, the current PCO agency must inform the consumer that a break in services will occur until the consumer selects an agency. The discharging agency may not ask the medicaid's designee to terminate the consumer's PCO services.

(3) A consumer has a right to appeal the agency's decision to suspend services as outlined in 8.352.2 NMAC, *Recipient Hearings*. A recipient has 90 days from the date of the suspension notice to request a fair hearing.

B. **Discharge by the state:** Medicaid or its designee reserves the right to exercise its authority to discontinue the consumer's receipt of PCO services due to the consumer's non-compliance with medicaid regulations and PCO service requirements. The consumer's discontinuation of PCO services does not affect his/her medicaid eligibility. The consumer may be discharged for a justifiable reason by means of a 30-day written notice to the consumer. The notice will include duration of discharge, which may be permanent, the consumer's right to request a fair hearing, pursuant to 8.352.2 NMAC, *Recipient Hearings*, and the justifiable reason for the decision to discharge. A justifiable reason for discharge may include:

(1) staffing problems (i.e., unjustified excessive requests for change in attendants three or more in a 30-day period), excessive requests for transfers to other agencies or excessive agency discharges;

(2) a consumer who demonstrates a pattern of verbal or physical abuse toward attendants, agency personnel, or state staff or contractors, including use of vulgar or explicit (i.e. sexually) language, verbal or sexual harassment, excessive use of force, demonstrates intimidating behavior, verbal or physical threats toward attendants, agency personnel, or state staff or contractors;

(3) a consumer or family member who demonstrates a pattern of uncooperative behavior including, not complying with agency, medicaid program requirements or regulations or procedures;

(4) illegal use of narcotics or alcohol abuse; and

(5) fraudulent submission of timesheets; or

(6) unsafe or unhealthy living conditions or environment.

C. PCO agencies, the TPA, and the MCO for CoLTS are all responsible for properly documenting and reporting any incidents involving a consumer that is described in Section B one through six above to medicaid or its designee.

[8.315.4.23 NMAC - Rp, 8.315.4.20 & 21 NMAC, 12-30-10; A, 9-15-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.1 NMAC, Sections 1, 2, 3, 6, 7, 8, 9, 10 and 13, effective September 22, 2011.

16.6.1.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.

[16.6.1.1 NMAC - N, 09-30-04; A, 9-22-11]

16.6.1.2 SCOPE: This part applies to the board, the naprapathic task force, licensees, applicants, and the general public.

[16.6.1.2 NMAC - N, 09-30-04; A, 9-22-11]

16.6.1.3 STATUTORY AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.

[16.6.1.3 NMAC - N, 09-30-04; 9-22-11]

16.6.1.6 OBJECTIVE: This part establishes definitions of terms for rules filed in this chapter, the purpose and organization structure of the [~~board~~] naprapathic task force, requirements for display of license, unlicensed practices prohibition, record keeping requirements and inspection of public records limitations.

[16.6.1.6 NMAC - N, 09-30-04; 9-22-11]

16.6.1.7 DEFINITIONS:

A. **"Applicant"** means a person who is applying to be licensed for the first time as a naprapath in New Mexico.

B. **"Naprapath"** means a person who practices naprapathy licensed by the board and has met all requirements.

C. **"Naprapathy"** means a branch of medicine, that focuses on the evaluation and treatment of neuro-musculoskeletal conditions. Doctors of naprapathy are connective tissue specialists.

[~~D. **"Superintendent"** means the superintendent of regulation and licensing department.~~]

[~~E.~~]D. **"Board"** means the [~~naprapathy practice~~] medical board.

[~~F. **"Department"** means the regulation and licensing department.~~]

[~~G.~~]E. **"Fund"** means the [~~naprapathy~~] New Mexico medical board fund.

[~~H.~~]F. **"License"** means an authorization by the [~~superintendent~~] board that permits a person to practice naprapathy in the state.

[~~I.~~]G. **"Licensee"** means a person licensed by the [~~superintendent as a naprapath~~] board to practice naprapathy.

[~~J. **"Director"** means the director of boards and commissions.~~]

[~~K.~~]H. **"Advertising"** means any communication whatsoever, disseminated by any means whatsoever, to or before the public or any portion therefore, with the intent of furthering the purpose, either directly or indirectly, of selling professional services, educating the public, or including members of the public to enter into any obligation relating to such professional services.

[~~L.~~]I. **"Revocation"** means a permanent loss of licensure.

[~~M.~~]J. **"Suspension"** means a loss of licensure for a certain period, after which the person may be required to file for reinstatement.

[~~N.~~]K. **"Complaint"** means a sworn written complaint.

[~~O.~~]L. **"Complainant"** means the complaining party of the complaint filed against a licensee or applicant for licensure, who is regulated by the [~~naprapathic practice~~] medical board.

[~~P.~~]M. **"Respondent"** means a licensee or applicant for licensure who is regulated by the [~~naprapathic practice~~] board.

[~~Q.~~]N. **"Notice of contemplated action"** means the administrative process used by the board for a licensee or applicant for licensure to be afforded notice and an opportunity to be heard in a formal hearing before the board has any authority to take any action which could result in denial, suspension, revocation, restricting, monitoring, censuring, etc., of a license or application or licensure.

[16.6.1.7 NMAC - N, 09-30-04; A, 9-22-11]

16.6.1.8 PURPOSE OF THE [~~BOARD~~] NAPRAPATHIC TASK FORCE: [~~The purpose of the board is to protect the heath, safety, and welfare of the public by ensuring that regulated professionals or licensed naprapaths and licenses meet prescribed standards of education, competence and practice. To~~

~~accomplish this mission, we will:~~

~~A. establish standards and measures to complete all board processes in a timely and effective manner;~~

~~B. provide open and immediate access to accurate and relevant public information to all users;~~

~~C. communicate the board's roles, responsibilities, and services as a consumer protection agency;~~

~~D. give priority attention to the elimination of unlicensed and potentially harmful activity;~~

~~E. invest in employees and board members through training and professional development;~~

~~F. develop and implement a long-range plan to ensure efficient, effective regulation, which provides consumer protection; it is further declared to be a matter of public interest and concern that the practice of naprapathy receives the confidence of the public and only qualified persons be authorized to practice naprapathy in the state of New Mexico.~~] The naprapathic task force shall advise the board regarding licensure of naprapaths, approval of naprapathy curricula and any other matters that are necessary to ensure the training and licensure of naprapaths.

[16.6.1.8 NMAC - N, 09-30-04; A, 9-22-11]

16.6.1.9 ORGANIZATION:

A. The naprapathic [~~practice board~~] task force is created [~~and administratively attached to the department~~] under the direction of the board.

[~~B. The board shall annually elect a president, vice president, and secretary-treasurer who shall be chosen among its members. Each officer shall hold office until his or her successors have been duly elected and qualified.~~

~~C. The board shall consist of five (5) members, three of which must be licensed naprapaths in the state of New Mexico. The governor shall appoint the members for four (4) year terms. No member shall serve more than two (2) terms, except that a person who is appointed to complete an un-expired term of a member of the board may also serve two (2) full terms.~~

~~(1) No board member shall be the owner, principal or director of an institute offering educational programs in naprapathy:~~

~~(a) a faculty member at an institute offering educational programs in naprapathy;~~

~~(b) a tutor in naprapathy; or~~

~~(c) an officer or director in a professional association of naprapathy.~~

~~(2) Paragraph (1) of this subsection shall become effective January 1, 2010.~~

~~D. **Meetings:** The board shall meet at least two (2) times per year for the purpose of transacting such business as may lawfully come before the board. Times and places of the meetings will be established by the board and advertised prior to the meetings. Three members shall conduct a quorum. Meetings will be conducted in compliance with the annual notice requirements adopted by the board.~~

~~E. **Committees:** The presiding officer at any meeting of the board is authorized to appoint special and standing committees from the membership and board approved licensees of the board. The duties of such committees shall be assigned at the time the committee is appointed.~~]

B. The naprapathic task force shall be composed of no fewer than two licensees, appointed by the board, who are residents of the state. Vacancies on the naprapathic task force shall be filled by appointment by the board.

[16.6.1.9 NMAC - N, 09-30-04; A, 07-31-08; A, 9-22-11]

16.6.1.10 DISPLAY OF LICENSE: Every licensee must display a current license issued by the [~~naprapathic practice~~] board in a conspicuous location where the holder practices naprapathy.

[16.6.1.10 NMAC - N, 09-30-04; A, 9-22-11]

16.6.1.13 INSPECTION OF PUBLIC RECORDS: [~~Only board members and board staff may have access to non-public records, unless approved by the board attorney or ordered by a court of competent jurisdiction.~~] Refer to Title 16, Chapter 10, Part 1 of the New Mexico medical board rules.

[16.6.1.13 NMAC - N, 09-30-04; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.2 NMAC, Sections 1, 2 and 3, effective September 22, 2011.

16.6.2.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.

[16.6.2.1 NMAC - N, 09-30-04; A, 9-22-11]

16.6.2.2 SCOPE: This part applies to [~~the board, licensees, and applicants, and the general public~~] applicants and licensees.

[16.6.2.2 NMAC - N, 09-30-04; A, 9-22-11]

16.6.2.3 STATUTORY AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.

[16.6.2.3 NMAC - N, 09-30-04; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.3 NMAC, Sections 1, 2, 3 and 8, effective September 22, 2011.

16.6.3.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.

[16.6.3.1 NMAC - N, 09-30-04; A, 9-22-11]

16.6.3.2 SCOPE: This part applies to [~~the board, licensees, applicants, and the general public~~] applicants, licensees, continuing education program providers and the general public.

[16.6.3.2 NMAC - N, 09-30-04; A, 9-22-11]

16.6.3.3 STATUTORY AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.

[16.6.3.3 NMAC - N, 09-30-04; A, 9-22-11]

16.6.3.8 FEES: All fees payable to the board are non-refundable.

A. **PROCESSING FEE:** $75.00. The board shall assess a processing fee for administrative processing of applications.

B. **INITIAL LICENSURE FEE:** $500.00. The initial licensure fee shall be five hundred dollars ($500.00) in addition to the processing fee.

C. **RENEWAL FEE:** $500.00. The renewal fee shall be five hundred dollars ($500.00) annually due no later than July 1st of each year. In the event that a licensee fails to renew their license by the deadline of any year, the board is required to assess a late fee. If an initial license is granted on or after April 1st of any year but before the license expiration date of June 30th the license will be good until the following year and the licensee will not be required to pay the renewal fee for the first year.

D. **LATE FEES:**

(1) $100.00 to 300.00. If a renewal is post-marked past the deadline of July 1st, the board is required to charge a late fee

(a) $100.00. Late fee after July 1 through August 1

(b) $200.00. Late fee after August 1 thru September 1

(c) $300.00. Late fee after September 1 through October 1

(2) If a licensee renews their license by October 1, they must submit a renewal application accompanied by the fee and late fee. If the licensee fails to renew their license by October 1 the licensee must reinstate their license as set forth in the

reinstatement procedures of the board.

E. **INACTIVE STATUS FEE:** $100.00. A licensee may submit a request in writing to the board office to be placed on inactive status. The fee for inactive status is one hundred dollars ($100.00) annually. Once a license is placed on inactive status, the licensee cannot practice naprapathy in New Mexico.

F. **REACTIVATION FROM INACTIVE STATUS:** $50.00. If the inactive licensee requests reactivation from inactive status to active status, the licensee must complete an application for reactivation form provided by the board. The licensee will be required to pay the renewal fee. The applicant may be required to re-take the national examination at the discretion of the board.

G. **REINSTATEMENT FEE:** $500.00. If the expired licensee requests to reinstate their license, the licensee will be required to pay a five hundred dollar ($500.00) reinstatement fee, renewal fee, the processing fee and submit a reinstatement application. The applicant may be required to re-take the national examination at the discretion of the board.

H. **DUPLICATE LICENSE:** $50.00. The fee for a duplicate of original certificate of licensure to replace a lost certificate of licensure, or a replacement certificate of licensure with a new name, or for a board verified copy of certificate of licensure shall be fifty dollars ($50.00).

I. **OTHER MISCELLANEOUS CHARGES:**

(1) license list [~~$ 7 5 . 0 0~~] $25.00

(2) license labels [~~$ 1 0 0 . 0 0~~] $50.00

(3) list/labels for commercial use $150.00

(4) copy fee; per page [~~$.25~~] $1.00

[~~(5) rules and regulations $10.00~~]

[~~(6)~~] (5) continuing education provider fee $75.00

[16.6.3.8 NMAC - N, 09-30-04; A, 07-31-08; A, 05-24-10; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.4 NMAC, Sections 1, 2 and 3, effective September 22, 2011

16.6.4.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.
[16.6.4.1 NMAC - N, 09-30-04; A, 9-22-11]

16.6.4.2 SCOPE: This part applies to [~~the board, licensees, applicants, and the general public~~] applicants and licensees.
[16.6.4.2 NMAC - N, 09-30-04; A, 9-22-11]

16.6.4.3 STATUTORY AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.
[16.6.4.3 NMAC - N, 09-30-04; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.5 NMAC, Sections 1, 2, 3, 6, 9 and 10, effective September 22, 2011.

16.6.5.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.
[16.6.5.1 NMAC - N, 09-30-04; A, 9-22-11]

16.6.5.2 SCOPE: This part applies to [~~the board, licensees, applicants, and the general public~~] licensed naprapaths as well as naprapaths who have previously held a license to practice in New Mexico and wish to inactivate a license, reinstate an inactive license or reinstate a license from expired status.
[16.6.5.2 NMAC - N, 09-30-04; A, 9-22-11]

16.6.5.3 STATUTORY AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.
[16.6.5.3 NMAC - N, 09-30-04; A, 9-22-11]

16.6.5.6 OBJECTIVE: This part establishes the requirements for placement of a license on inactive status, reinstatement from inactive status and reinstatement from expired status.
[16.6.5.6 NMAC - N, 09-30-04; A, 9-22-11]

16.6.5.9 REINSTATEMENT FROM INACTIVE STATUS: If an inactive licensee requests to reinstate their license; the licensee is required to:

A. pay the reinstatement fee and renewal fee established by the board to reinstate their license as defined in 16.6.3.8 NMAC;

B. submit a reinstatement application provided by the board office;

C. submit 30 continuing professional education (CPE) hours for every year licensee has been inactive as defined in 16.6.6 NMAC;

D. submit verification of licensure, if licensed or previously licensed in another state(s) or jurisdiction; verification [~~must~~] shall be sent directly to the board office from the issuing state(s) or jurisdiction; and

E. the applicant may be required to take the national examination at the discretion of the board.

[16.6.5.9 NMAC - N, 05-24-10; A, 9-22-11]

16.6.5.10 REINSTATEMENT FROM EXPIRED STATUS: If an expired licensee requests to reinstate their license; the licensee is required to:

A. pay the reinstatement fee, processing fee and renewal fee established by the board to reinstate their license as defined in 16.6.3.8 NMAC;

B. submit [~~an~~] a reinstatement application provided by the board office;

C. submit 30 continuing professional education (CPE) hours for every year the license has been expired as defined in 16.6.6 NMAC;

D. submit verification of licensure, if licensed or previously licensed, in another state(s) or jurisdiction; verification [~~must~~] shall be sent directly to the board office from the issuing state(s) or jurisdiction; and;

E. the applicant may be required to take the national examination at the discretion of the board.

[16.6.5.10 NMAC - N, 05-24-10; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.6 NMAC, Sections 1, 2, 3, and 8, effective September 22, 2011.

16.6.6.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.
[16.6.6.1 NMAC - N, 09-30-04; A, 9-22-11]

16.6.6.2 SCOPE: This part applies to [~~the board, licensees, applicants, and the general public~~] licensed naprapaths as well as naprapaths who have previously held a license to practice in New Mexico and wish to reinstate an inactive license or reinstate a license from expired status.
[16.6.6.2 NMAC - N, 09-30-04; A, 9-22-11]

16.6.6.3 STATUTORY AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.
[16.6.6.3 NMAC - N, 09-30-04; A, 9-22-11]

16.6.6.8 CONTINUING EDUCATION:

A. The licensee [~~must~~]

shall report thirty (30) hours of continuing professional education hours (CPE) per year at the time of renewal. Three (3) of the thirty (30) continuing education hours [~~must~~] shall be in ethics.

B. The naprapathic [~~practice board~~] task force shall make recommendations to the [~~superintendent~~] board for approval of continuing education courses that meet standard requirements.

C. A licensee that has allowed a license to expire and is seeking reinstatement, must conform to continuing education licensure requirements from the date the license expired.

[16.6.6.8 NMAC - N, 09-30-04; A, 05-24-10; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.7 NMAC, Sections 1, 2, 3, and 8, effective September 22, 2011.

16.6.7.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.

[16.6.7.1 NMAC - N, 10-1-04; A, 9-22-11]

16.6.7.2 SCOPE: This part applies to [~~the board, licensees, applicants, and the general public~~] naprapathic physicians applying for licensure in New Mexico.

[16.6.7.2 NMAC - N, 10-1-04; A, 9-22-11]

16.6.7.3 S T A T U T O R Y AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.

[16.6.7.3 NMAC - N, 10-1-04; A, 9-22-11]

16.6.7.8 LICENSURE BY ENDORSEMENT OR EXAMINATION: [~~The superintendent may, at the recommendation from the board, issue a license~~] A license may be issued to practice naprapathy to individuals who satisfy the following criteria:

A. is at least twenty-one years of age;

B. has graduated from a two-year college-level program or an equivalent program approved by the [~~superintendent~~] board after consultation with the [~~board~~] naprapathic task force;

C. has completed, in not less than three years, a four-year academic curriculum in naprapathy, that is approved by the board after consultation with the naprapathic task force, and the person has successfully completed one hundred thirty-two hours of academic credit, including sixty-six credit hours in basic science courses with emphasis on the study of connective tissue, and sixty-six credit hours in clinical naprapathic science, theory and application;

D. passed the national examination administered by the national board of naprapathic examiners and provides the board with evidence of successful completion or holds a current valid license in good standing as a naprapath in another state(s), jurisdiction, Sweden, Norway or Finland;

E. provide two (2) letters of recommendation from individuals licensed as a naprapath, in good standing, at the time the letters were written;

F. provide one (1) letter of personal reference from anyone with whom the applicant has worked with the past three years;

G. verification of licensure, if licensed or previously licensed in another state or jurisdiction; verification must be sent directly to the board office from the issuing state(s) or jurisdiction; and;

H. has met all other requirements of the Naprapathic Practice Act.

[16.6.7.8 NMAC - N, 10-1-04; A, 05-24-10; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.8 NMAC, Sections 1, 2, 3, 6, 8, 9 and 10, effective September 22, 2011.

16.6.8.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.

[16.6.8.1 NMAC - N, 09-30-04; A, 9-22-11]

16.6.8.2 SCOPE: This part applies to [~~the board, licensees, applicants, and the general public~~] applicants and licensees.

[16.6.8.2 NMAC - N, 09-30-04; A, 9-22-11]

16.6.8.3 S T A T U T O R Y AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.

[16.6.8.3 NMAC - N, 09-30-04; A, 9-22-11]

16.6.8.6 OBJECTIVE: This part establishes diagnostic procedures, meridian therapy and rehabilitation of the [~~neuromusculoskeletal~~] neuromusculoskeletal system.

[16.6.8.6 NMAC - N, 09-30-04; A, 9-22-11]

16.6.8.8 D I A G N O S T I C PROCEDURES:

A. Naprapathic physicians are authorized to perform diagnostic procedures specified in this regulation, which shall include the authority to perform and take:

(1) medical case history;

(2) physical examination of all body systems including, but not limited to:

(a) skin, hair, nails, head, eyes, ears, nose;

(b) [~~cardio-vascular~~] cardiovascular and respiratory system, including auscultation;

(c) [~~musculo-skeletal~~] musculoskeletal system;

(d) neurological system.

B. [~~Authority to order diagnostic procedures~~] Naprapathic physicians are authorized to order any diagnostic procedure from any recognized laboratory or imaging facility reasonably necessary to clinically correlate a physical examination to a diagnostic impression; which shall include, but not be limited to laboratory procedures involving the collection of human fluids, such as saliva, blood, urine, [~~vaginal and seminal fluids~~], hair, feces and special imaging, such as x-ray; CT scan, MRI, nuclear scans, ultrasonography, thermography, [~~B.E.A.M.~~] beaches emergency assistance ministry (B.E.A.M.), EEG, EKG, ECG and surface or needle EMG.

[16.6.8.8 NMAC - N, 09-30-04; A, 9-22-11]

16.6.8.9 M E R I D I A N THERAPY:

A. Naprapaths who practice meridian therapy [~~must~~] shall do so in conjunction with standard naprapathic adjusting [~~and/or~~] and manipulative techniques.

B. Naprapaths who practice meridian therapy may not advertise or promote themselves in the media to be acupuncturists unless licensed pursuant to the Acupuncture Act.

[16.6.8.9 NMAC - N, 09-30-04; A, 9-22-11]

16.6.8.10 REHABILITATION OF THE [~~NEUROMUSCULOSKETAL~~] N E U R O M U S C U L O S K E L E T A L SYSTEM: Naprapathic physicians may use all necessary mechanical, hygienic and sanitary measures incident to the care of the body including but not limited to air, sound, cold, diet, exercise, heat, light, massage, physical culture, rest, ultrasound, water, and electricity.

[16.6.8.10 NMAC - N, 09-30-04; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.9 NMAC, Sections 1, 2, 3 and 8, effective September 22, 2011.

16.6.9.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.
[16.6.9.1 NMAC - N, 09-30-04; A, 9-22-11]

16.6.9.2 SCOPE: This part applies to the [~~board, licensees, applicants, and the general public~~] applicants, intern naprapaths and licensees.
[16.6.9.2 NMAC - N, 09-30-04; A, 9-22-11]

16.6.9.3 STATUTORY AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.
[16.6.9.3 NMAC - N, 09-30-04; A, 9-22-11]

16.6.9.8 SUPERVISION OF INTERNS:

A. The purpose for the intern program in New Mexico shall be to safely complete advanced training for the graduating naprapathic intern in the areas including, but not limited to, history taking, exams, patient report of findings, treatment recommendations, treatment room control, staff management, general clinic policies, problem solving skills, team concepts, goal setting, administrative skills, and other training the doctor may feel appropriate to complete the intern's advanced naprapathic training. This purpose enhances the professional training of the intern, the naprapathic college curriculum, the teaching skills of the doctor, the professional status of the profession of naprapathic and the professional standard of naprapathic health care available to New Mexico consumers.

B. Supervising doctor must have a current New Mexico license in "good standing" with the [~~New Mexico~~] board [~~of naprapathic examiners~~] and have been treating patients as a naprapath for at least three years.

C. Supervising doctor must have written verification from the college that the intern is in a CCE, or board approved equivalent thereof, accredited naprapathic college sanctioned intern program, and the doctor must assure compliance to the guidelines of the intern program.

D. Supervising doctor must personally train intern in naprapathic procedure.

E. Supervising doctor must be physically in the same treatment room overseeing the intern to provide care for any patient.

F. Public must be informed that the intern is an "intern naprapath, not licensed in the state", and must sign an informed consent document approved by the board to this effect.

G. Supervising doctor may allow intern to assist in various exams and therapies after being trained and cleared by the supervising doctor on proper naprapathic procedures.

H. The supervising doctor must inform the college if the intern is deemed professionally competent in the diagnosis or treatment of naprapathic patients.

I. A supervising doctor may not supervise more than two interns at one time.

J. Supervising doctor [~~must~~] shall register with the [~~New Mexico~~] board [~~of naprapathic practice examiners~~] the interns' names, the college they are from, and the term of the internship, and provide proof of malpractice insurance for the supervising doctor in a minimum amount of $1,000,000 per person - $3,000,000 per occurrence coverage, at least 15 days before the first day of the internship.

K. The board is to be sent a copy of any report sent to the college involving the intern at the time the report is sent to the college.
[16.6.9.8 NMAC - N, 09-30-04; A, 05-24-10; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.6.11 NMAC, Sections 1, 3 and 11, effective September 22, 2011.

16.6.11.1 ISSUING AGENCY: New Mexico [~~Naprapathic Practice Board~~] Medical Board, hereafter called the board.
[16.6.11.1 NMAC - N, 09-30-04; A, 9-22-11]

16.6.11.3 STATUTORY AUTHORITY: This part is adopted pursuant to and in accordance with the Naprapathic Practice Act, [~~Sections 61-12E-1 through 61-12E-17 NMSA 1978~~] Sections 61-12F-1 through 61-12F-11 NMSA 1978.
[16.6.11.3 NMAC - N, 09-30-04; A, 9-22-11]

16.6.11.11 INITIAL ACTION: Upon determination that an applicant or licensee appears on the certified list, the board shall:

A. commence a formal proceeding in accordance with the Uniform Licensing Act (61-1-1 et seq.) to take the appropriate action pursuant to the Parental Responsibility Act; or

B. for current licensees only, informally notify the licensee that the licensee's name is on the certified list, and that the licensee must provide the board with a subsequent statement of compliance from HSD [~~by the earlier of the application~~] for license renewal or a specified date not to exceed thirty days; if the licensee fails to provide this statement, the board shall commence a formal proceeding in accordance with the Uniform Licensing Act.
[16.6.11.11 NMAC - N, 09-30-04; A, 9-22-11]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.10.4 NMAC, Section 11, effective September 22, 2011.

16.10.4.11 ALLOWED COURSES AND PROVIDERS: The following courses and activities are acceptable for CME credit:

A. AMA PRA Category 1 Credit™ Clinical courses, lectures or grand rounds certified by an accredited sponsor of the AMA physician's recognition award, **AMA PRA Category 1 Credit™** are acceptable for credit whether taken in an on-site format or taken using the internet.

B. NEW MEXICO SPECIFIC CME. Activities certified by the New Mexico medical society (NMMS) continuing medical education committee are acceptable for credit. Up to forty (40) credits in any three-year reporting period are allowed for participation in activities certified as New Mexico specific CME by the NMMS continuing education committee. New Mexico specific CME are issued by the NMMS for service on the New Mexico medical review commission and on the impaired physician committee.

C. POST GRADUATE EDUCATION. A maximum of seventy-five (75) credit hours in any three-year reporting period are allowed for participation in a postgraduate education program, which has been approved by the board or by the AMA liaison committee on graduate medical education. This category includes internships, residencies and fellowships.

D. ADVANCED DEGREES. Forty (40) credit hours are allowed for each full academic year of study toward an advanced degree in a medical field or a medically related field as approved by the board.

E. TEACHING. One credit hour is allowed for each hour of teaching medical students or physicians in a United States medical school, an approved internship or residency or for teaching in other programs approved by the board for a

maximum of forty (40) credit hours in any three-year reporting period.

F. PHYSICIAN PRECEPTORS. A maximum of thirty (30) hours of credit during a three year reporting period is acceptable for licensed physicians who are acting as preceptors for students enrolled in an accredited medical or physician assistant school or as preceptors for students enrolled in a combined bachelor of arts and medical degree program.

G. PAPERS AND PUBLICATIONS. Ten (10) hours of credit are allowed for each original scientific medical paper or publication written by a licensee. For acceptance, papers must have been presented to a recognized national, international, regional or state society or organization whose membership is primarily physicians; or must have been published in a recognized medical or medically related scientific journal. Material used in a paper or publication may be given credit one time. A maximum of thirty (30) hours credit may be claimed during each three-year reporting period.

H. ADVANCED LIFE SUPPORT. Credit may be claimed during each three-year reporting period for successful completion of ACLS (advanced cardiac life support), PALS (pediatric advanced life support), ATLS (advanced trauma life support), NALS (neonatal advanced life support), and ALSO (advanced life support in obstetrics) courses.

I. EXPERT REVIEW. Credit may be claimed by physicians who provide expert services by reviewing investigation cases for the board. A maximum of ten (10) credit hours in any three-year reporting period are allowed for providing expert review.

[16.10.4.11 NMAC - Rp 16 NMAC 10.4.8, 4/18/02; A, 4/3/05; A, 9/27/07; A, 1/2/08; A, 7/1/10; A, 9/22/11]

NEW MEXICO COMMISSION OF PUBLIC RECORDS

Notice of Repeal

1.18.366 NMAC, Executive Records Retention and Disposition Schedule for the Public Employees Retirement Association, is being repealed and replaced with the new 1.18.366 NMAC, Executive Records Retention and Disposition Schedule for the Public Employees Retirement Association, effective September 26, 2011. The New Mexico Commission of Public Records at their August 23, 2011 meeting repealed the current rule and approved the new rule.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

August 23, 2011

Leo R. Lucero, Agency Analysis Bureau Chief
NM Commission of Public Records
1205 Camino Carlos Rey
Santa Fe, New Mexico 87505

Mr. Lucero:

You recently requested to publish a synopsis in lieu of publishing the full content of the following rule:
* 1.18.366 NMAC ERRDS, Public Employees Retirement Association

A review of this rule shows that its impact is limited to the individual agency to which it pertains, and it is "unduly cumbersome, expensive or otherwise inexpedient" to publish. Therefore, your request to publish a synopsis for it is approved.

Sincerely,

Sandra Jaramillo
State Records Administrator

SJ/lrl

NEW MEXICO COMMISSION OF PUBLIC RECORDS

SYNOPSIS
1.18.366 NMAC ERRDS, Public Employees' Retirement Association

1. Subject matter: 1.18.366 NMAC, Executive Records Retention and Disposition Schedule for the Public Employees' Retirement Association. This rule is new and replaces 1.18.366 NMAC ERRDS, Public Employees' Retirement Association, an outdated version that was filed on 3/9/2000. This records retention and disposition schedule is a timetable for the management of specific records series of the Public Employees' Retirement Association. It describes each record series by record name, record function, record content, record filing system, record confidentiality, and record retention. The record retention is the life cycle of each records series. It indicates the retention or length of time a record series must be maintained by the department as well as its final disposition. The retention and disposition requirements in this rule are based on the legal and use requirements of the records as well as on their administrative, fiscal and archival value. This rule was developed by the Records Management Division of the State Records Center and Archives (New Mexico Commission of Public Records) and approved by the State Records Administrator, the New Mexico Commission of Public Records and the Public Employees' Retirement Association.

2. Persons affected: The persons affected are the record producing and record keeping personnel of the Public Employees' Retirement Association. Persons and entities normally subject to the rules and regulations of the Public Employees' Retirement Association may also be directly or indirectly affected by this rule.

3. Interests of persons affected: Interests include the records produced and maintained by the Public Employees' Retirement Association.

4. Geographical applicability: Geographical applicability is limited to areas within the State of New Mexico covered by the Public Employees' Retirement Association. Any person or entity outside the covered geographical area that conducts business with or through the Public Employees' Retirement Association may also be affected by this rule.

5. Commercially published materials incorporated: The New Mexico Statutes Annotated 1978 were used as reference in the development of this rule. However, they do not constitute a substantial portion of this rule.

6. Telephone number and address of issuing agency: New Mexico State Records Center and Archives, 1205 Camino Carlos Rey, Santa Fe, New Mexico 87505. Telephone number: (505) 476-7900.

7. Effective date of this rule: September 26, 2011.

Certification

As counsel for the State Records Center and Archives, I certify that this synopsis provides adequate notice of the content of 1.18.366 NMAC, ERRDS, Public Employees' Retirement Association.

Tanya Maestas Date
Assistant Attorney General

End of Adopted Rules Section

Submittal Deadlines and Publication Dates
2011

Volume XXII	Submittal Deadline	Publication Date
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

Submittal Deadlines and Publication Dates
2012

Volume XXIII	Submittal Deadline	Publication Date
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Issue Number 3	February 1	February 15
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Issue Number 5	March 1	March 15
Issue Number 6	March 16	March 30
Issue Number 7	April 2	April 16
Issue Number 8	April 17	April 30
Issue Number 9	May 1	May 15
Issue Number 10	May 16	May 31
Issue Number 11	June 1	June 14
Issue Number 12	June 15	June 29
Issue Number 13	July 2	July 16
Issue Number 14	July 17	July 31
Issue Number 15	August 1	August 15
Issue Number 16	August 16	August 30
Issue Number 17	August 31	September 14
Issue Number 18	September 17	September 28
Issue Number 19	October 1	October 15
Issue Number 20	October 16	October 30
Issue Number 21	November 1	November 15
Issue Number 22	November 16	November 30
Issue Number 23	December 3	December 14
Issue Number 24	December 17	December 31

The *New Mexico Register* is the official publication for all notices of rule making, proposed rules, adopted rules, emergency rules, and other material related to administrative law. The Commission of Public Records, Administrative Law Division publishes the *New Mexico Register* twice a month pursuant to Section 14-4-7.1 NMSA 1978.

The New Mexico Register is available free online at **http://www.nmcpr.state.nm.us/nmregister.**

For further information, call 505-476-7907.