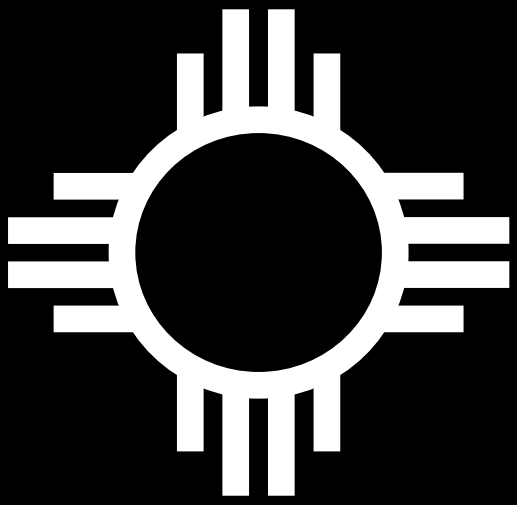
NEW MEXICO REGISTER



Volume XXIII
Issue Number 19
October 15, 2012

New Mexico Register

Volume XXIII, Issue Number 19
October 15, 2012

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
2012

New Mexico Register

Volume XXIII, Number 19
October 15, 2012

Table of Contents

Notices of Rulemaking and Proposed Rules

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A=***Amended***, E=***Emergency***, N=***New***, R=***Repealed***, Rn=***Renumbered***

Other Material Related to Administrative Law

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

The *New Mexico Register*
Published by
The Commission of Public Records
Administrative Law Division
1205 Camino Carlos Rey
Santa Fe, NM 87507

The *New Mexico Register* is published twice each month by the Commission of Public Records, Administrative Law Division. The cost of an annual subscription is $270.00. Individual copies of any Register issue may be purchased for $12.00. Subscription inquiries should be directed to: The Commission of Public Records, Administrative Law Division, 1205 Camino Carlos Rey, Santa Fe, NM 87507. Telephone: (505) 476-7907; Fax (505) 476-7910; E-mail staterules@state.nm.us.

Notices of Rulemaking and Proposed Rules

NEW MEXICO GAME COMMISSION

STATE GAME COMMISSION PUBLIC MEETING AND RULE MAKING NOTICE

On **Thursday, November 1, 2012**, beginning at 9:00 a.m., it the **Colfax County Commission Chambers, Colfax County Courthouse 3rd Floor, 230 North 3rd Street, Raton, NM 87740**, the State Game Commission will meet in public session to hear and consider action as appropriate on the following: revocations, depredation and nuisance abatement report for FY 2012 and Q1 FY 2013, proposed acquisition of the Lovejoy and Weaver properties to expand Lesser Prairie Chicken areas, biennial review of state listed threatened and endangered species, and establishment of application deadline for the 2013-2014 public big game draws. Additionally they will hear and consider action as appropriate on proposed amendments to the following rules: Hunter Education, Turkey, Pronghorn Antelope and Pronghorn License Allocation System, Hunter Trapper Reporting System, Barbary Sheep, Oryx, Persian, Ibex, Deer, Elk, Pronghorn Antelope, Bighorn Sheep and Javelina, the Use of Department of Game and Fish Lands, Protection of Department of Game and Fish Lands and Wildlife Management Area Rules, Artificial Light Permit System; and general public comments (comments are limited to three minutes). A closed executive session is planned to discuss matters related to personnel, litigation, and or real property.

Obtain a copy of the agenda from the Office of the Director, New Mexico Department of Game and Fish, P.O. Box 25112, Santa Fe, New Mexico 87504, or from the Department's website. This agenda is subject to change up to 24 hours prior to the meeting. Please contact the Director's Office at (505) 476-8008, or the Department's website at www.wildlife.state.nm.us for updated information.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing or meeting, please contact Sonya Quintana at (505) 476-8027. Please contact Ms. Quintana at least three working days before the meeting date. Public documents, including the Agenda and Minutes are provided in various accessible forms upon request.

NEW MEXICO PUBLIC REGULATION COMMISSION

BEFORE THE NEW MEXICO PUBLIC REGULATION COMMISSION

Case No. 12-00332-UT
IN THE MATTER OF THE ADOPTION OF A PROPOSED RULE GOVERNING COGENERATION AND SMALL POWER PRODUCTION

NOTICE OF PROPOSED RULEMAKING

NOTICE is hereby given that the New Mexico Public Regulation Commission is commencing a rulemaking proceeding for the purpose of promulgating a revised rule that would govern cogeneration and small power production. The Proposed Rule is intended to make the Commission's existing Rule 17.9.570 NMAC consistent with current federal and state law. A copy of the Proposed Rule is attached hereto as Attachment A.

THE COMMISSION FINDS AND CONCLUDES:

1. The Commission has the authority to promulgate the proposed rule amendments under the N.M. Const. art. XI, Section 2, and under NMSA 1978, Sections 8-8-4 (1998) and 8-8-15 (amended 2001).

2. The Proposed Rule would update the current Rule 17.9.570 to reflect changes in the federal Public Utility Regulatory Policies Act and the enactment of the Renewable Energy Act. It adds definitions to the Commission's existing rule related to purchases made by the electric utility on (1) an "as available" basis or (2) pursuant to a "legally enforceable obligation." The proposed rule changes are also intended to provide further direction on how rates are to be determined for purchases from qualifying facilities. Finally, the proposed rule delineates the terms related to the ownership of associated renewable energy certificates when the utility is purchasing energy from a qualifying facility that is not selling renewable energy pursuant to the Renewable Energy Act.

3. The Proposed Rule would also amend 17.9.570.14 to require electric utility companies to offer crediting of excess energy to be used by a customer to offset future energy usage and remove the present option provided to the utility to offer crediting if the utility itself opts to do so.

4. Interested persons may comment on any portion of the Proposed Rule.

5. This NOPR should constitute due and lawful notice to all potentially interested persons.

6. Commission Rule 1.2.3.7(B) NMAC (Ex Parte Communications) draws a distinction applicable to rulemaking proceedings between communications occurring before the record has been closed and communications occurring after the record has been closed. It defines only the latter as "ex parte communications." In order to ensure compliance with Rule 1.2.3.7(B) NMAC, the Commission should set a date on which it will consider the record to be closed. The Commission finds that date shall be the earlier of thirty (30) days following the **November 20, 2012, Public Hearing**, that is, **December 20, 2012**, or the date a Final Order is issued in this case. The setting of that record closure date will permit Commissioners and Commission Counsel to conduct follow-up discussions with parties who have submitted initial or response comments to the Commission's Proposed Rule or responses to any bench requests. However, this action should not be interpreted as extending the time during which parties may file comments or response comments, or as allowing the filing of other types of documents in this case.

7. Additional copies of the Proposed Rule can be obtained from:

Mr. Nick Guillen
NMPRC Records Management Bureau
1120 Paseo de Peralta
Santa Fe, New Mexico 87501

or

Mr. Nick Guillen
NMPRC Records Management Bureau
P.O. Box 1269
Santa Fe, New Mexico 87504-1269

or by calling 505-827-4366.

IT IS THEREFORE ORDERED:

A. The rulemaking proceeding shall be, and hereby is, instituted in this Docket and shall concern the promulgation of a rule pertaining to cogeneration and small power production, Rule 17.9.570 NMAC.

B. This *Notice of Proposed Rulemaking* constitutes due and lawful notice to all potentially interested persons.

C. Any person wishing to comment on the Proposed Rule may do so by submitting written comments no later than **October 22, 2012.** Any person wishing to respond to comments may do so by submitting written response comments no later than **October 29, 2012.** Comments suggesting changes to the Proposed Rule shall state and discuss the particular reasons for the suggested changes and shall include all specific language necessary or appropriate to effectuate the changes being suggested. Specific proposed language changes to the Proposed Rule shall be provided in a form consistent with that of the Proposed Rule. Commenters' deletions shall be indicated by striking through the language to be deleted; additions shall be underlined.

D. All pleadings, including comments, shall bear the above caption and case number **12-00332-UT** and shall be filed with the Commission's Records Division, at either of the addresses set out in paragraph 11 above.

E. A public hearing on the Proposed Rule, to be presided over by the Commission or its designee, shall be held beginning at **1:00 p.m. on November 20, 2012,** at the offices of the Commission, at the following location:

4th Floor Hearing Room
1120 Paseo de Peralta
Santa Fe, New Mexico 87501
Tel. 505-827-4366

The hearing will be held in order to receive oral comments and to clarify or supplement the written comments. No testimony or other evidence will be taken at the hearing as this is a rulemaking proceeding.

F. All persons providing public comment and/or participating in the public hearing are encouraged to provide specific comments on the Proposed Rule. Commenters are also encouraged to address any other topic that may be relevant to this rulemaking.

G. Interested persons should contact the Commission to confirm the date, time, and place of any public hearing, because hearings are occasionally rescheduled. Any person with a disability requiring special assistance in order to participate in the hearing should contact Ms. Cecilia Rios at (505) 827-4501 at least 48 hours prior to the commencement of the hearing.

H. Pursuant to NMSA 1978, Section 8-8-15(B) (amended 2001), at least thirty days prior to the hearing date, this *Notice of Proposed Rulemaking*, including Attachment A, shall be mailed to all persons who have made a written request for advance notice and shall be published without Attachment A in at least two newspapers of general circulation in New Mexico and in the New Mexico Register. Affidavits attesting to the publication of this *Notice of Proposed Rulemaking* as described above shall be filed in this Docket.

I. Copies of this *Notice of Proposed Rulemaking*, including Attachment A, shall be e-mailed to all persons listed on the attached Certificate of Service if their e-mail addresses are known, and if not known, mailed to such persons via regular mail.

J. This *Notice of Proposed Rulemaking* shall be posted on the Commission's official Web site.

K. Copies of any forthcoming final order adopting a new rule shall be mailed, along with copies of the new rule, to all persons and entities appearing on the Certificate of Service as it exists at the time of issuance of the final order in this Docket, to all commenters in this case, and to all individuals requesting such copies.

L. This *Notice of Proposed Rulemaking* is effective immediately.

ISSUED under the Seal of the Commission at Santa Fe, New Mexico this 27th day of September, 2012.

NEW MEXICO PUBLIC REGULATION COMMISSION
PATRICK H. LYONS, CHAIRMAN
THERESA BECENTI-AGUILAR, VICE CHAIR
JASON A. MARKS, COMMISSIONER
DOUGLAS J. HOWE, COMMISSIONER
BEN L. HALL, COMMISSIONER

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

NOTICE OF HEARING AND PROPOSED RULES

The New Mexico Taxation and Revenue Department proposes to adopt the following rules under the Gross Receipts and Compensating Tax Act:

Section 7-9-51 NMSA 1978
3.2.209.25 NMAC - **Carpets and Draperies Installed in a Construction Project**

Section 7-9-52 NMSA 1978
3.2.210.24 NMAC - **Construction-related Inspection Services**
3.2.210.25 NMAC - **Transactions Involving Construction-related Services**

Section 7-9-52.1 NMSA 1978
3.2.249.8 NMAC - **Leased Items Used on a Construction Project - Oil Field**
3.2.249.9 NMAC - **Lease of Construction Equipment**

The New Mexico Taxation and Revenue Department proposes to amend the following rules under the Gross Receipts and Compensating Tax Act:

Section 7-9-3.4 NMSA 1978
3.2.1.7 NMAC - **Definitions**
3.2.1.11 NMAC - **Construction**

Section 7-9-3.5 NMSA 1978
3.2.1.16 NMAC - **Gross Receipts - Real Estate and Intangible Property**
3.2.1.17 NMAC - **Gross Receipts - Leasing**
3.2.1.18 NMAC - **Gross Receipts; Services**

Section 7-9-7 NMSA 1978
3.2.10.13 NMAC - **Construction Projects Occupied or Leased Prior to Sale**

Section 7-9-43 NMSA 1978
3.2.201.8 NMAC - **Possession and Delivery of Nontaxable Transaction Certificates - Types of Certificates**
3.2.201.11 NMAC - **Construction Contractors**

Section 7-9-48 NMSA 1978
3.2.206.12 NMAC - **Nonconstruction Services Sold to Construction Contractors**

Section 7-9-52 NMSA 1978
3.2.210.8 NMAC - **General Business Services are not Construction Services or Construction-Related Services**
3.2.210.9 NMAC - **Well Construction**

Services
3.2.210.10 NMAC - **Hauling Services**
3.2.210.14 NMAC - **Salvaging of a "Production Unit"**
3.2.210.15 NMAC - **Cleaning the Construction Site**
3.2.210.16 NMAC - **Damage to a Construction Project by Subcontractor**
3.2.210.18 NMAC - **Laboratory Work and Environmental Testing**
3.2.210.19 NMAC - **Construction-related Services and Associated Products**
3.2.210.20 NMAC - **Compensating Tax on Construction Services**
3.2.210.21 NMAC - **Mud Engineering Services**
3.2.210.22 NMAC - **Lease of Construction Equipment**

The New Mexico Taxation and Revenue Department proposes to repeal the following rules under the Gross Receipts and Compensating Tax Act:

Section 7-9-51 NMSA 1978
3.2.209.22 NMAC - **Ingredient and Component Parts of a Construction Project**

Section 7-9-52 NMSA 1978
3.2.210.7 NMAC - **Definitions: Hauling and Spreading Defined**
3.2.210.12 NMAC - **Sweat Labor Contract**

These proposals were placed on file in the Office of the Secretary on October 8, 2012. Pursuant to Section 9-11-6.2 NMSA 1978 of the Taxation and Revenue Department Act, the final of these proposals, if filed, will be filed as required by law on or about December 14, 2012.

A public hearing will be held on these proposals on Monday, November 19, 2012, at 9:30 a.m. in the Secretary's Conference Room No. 3002/3137 of the Taxation and Revenue Department, Joseph M. Montoya Building, 1100 St. Francis Drive, Santa Fe, New Mexico. Auxiliary aids and accessible copies of the proposals are available upon request; contact (505) 827-0928. Comments on the proposals are invited. Comments may be made in person at the hearing or in writing. Written comments on the proposals should be submitted to the Taxation and Revenue Department, Director of Tax Policy, Post Office Box 630, Santa Fe, New Mexico 87504-0630 on or before November 19, 2012.

3.2.209.25 CARPETS AND DRAPERIES INSTALLED IN A CONSTRUCTION PROJECT: When carpets or draperies are to be installed as an ingredient or component part of a construction project a person engaged in the construction business may deliver a nontaxable transaction certificate for the purchase of carpet or draperies, or the installation of carpets or draperies, to the seller and the seller may deduct receipts from the sale pursuant to Section 7-9-51 NMSA 1978.
[3.2.209.25 NMAC - N, XXX]

3.2.210.24 CONSTRUCTION-RELATED INSPECTION SERVICES:

A. The receipts from the sale of inspection services to a person engaged in the construction business may be deducted from the seller's gross receipts pursuant to Section 7-9-52 NMSA 1978 when they are directly contracted for or billed to a specific construction project and if all the requirements of Section 7-9-52 NMSA 1978 are met. These inspection services include but are not limited to:

(1) field sampling or testing of construction components in order to comply with building codes; and

(2) stormwater runoff testing and routine inspections for compliance with permits required under the federal Clean Water or Clean Air Acts.

B. Example 1: C is engaged in the construction business. C obtains the services of either H, a certified home energy rating system (HERS) or L, a leadership in energy and environmental design (LEED) consultant to perform inspections and make recommendations for compliance with the state's energy conservation code. The receipts from the services performed by H or L are deductible under Section 7-9-52 NMSA 1978 when they are directly contracted for or billed to a specific construction project and if all the requirements of Section 7-9-52 NMSA 1978 are met.

C. Example 2: X is engaged in the construction business. X obtains the services of Y, an engineering service company to perform the weld inspection and testing required as a "special inspection" under provisions of the state's commercial building code. Y also provides a "special inspection" service that includes inspecting forming and reinforcing rods, and observing concrete being poured. Both of these services are deductible under Section 7-9-52 NMSA 1978 when they are directly contracted for or billed to a specific construction project and if all the requirements of Section 7-9-52 NMSA 1978 are met.

D. Example 3: S is engaged in the construction business. S obtains the services of W, a stormwater professional, to prepare a federally-required SWPPP and monitor the quality of stormwater runoff by writing reports, suggesting additional best management practices, and sending samples to a testing lab. Even though S is not in the business of selling construction-related services, S may issue nttcs to W, and the testing laboratories (if they bill separately) as those are construction-related services deductible under Section 7-9-52 NMSA 1978 when they are directly contracted for or billed to a specific construction project and if all the requirements of Section 7-9-52 NMSA 1978 are met.

E. This version of 3.2.210.23 NMAC applies to transactions occurring on or after January 1, 2013.
[3.2.210.24 NMAC - N, XXX]

3.2.210.25 TRANSACTIONS INVOLVING CONSTRUCTION-RELATED SERVICES: The following are examples of transactions that involve construction-related services and how the deduction for these services under Section 7-9-52 NMSA 1978 may or may not apply to the specific facts of these transactions.

A. Example 1: X is a general contractor who has been hired to design and build an office building. In addition to the typical construction service subcontractors, X also hires an Y, an engineering firm and Z, an architect, to perform construction-related services that are directly contracted for this particular construction project. If X provides Y and Z with an appropriate nontaxable transaction certificate, Y and Z can take the deduction for construction-related services under Section 7-9-52 NMSA 1978.

B. Example 2: T, a construction contractor, hires S, a security firm, to provide security services at T's ten construction sites. S has experienced some recent employment turnover and does not have enough employees to provide security services for all of T's construction sites. As a result, S is required to subcontract with W, an independent security company for two of the construction sites. T executes a nontaxable transaction certificate (nttc) pursuant to Section 7-9-52 NMSA 1978 to S for the security services for the ten construction sites which allows S to take the construction-related service deduction under Section 7-9-52 NMSA 1978.

C. The receipts from the services provided by W to S are subject to gross receipts tax unless a specific exemption or deduction applies. The deduction under Section 7-9-52 NMSA 1978 does not apply to this transaction, because S is not a person engaged in the construction business and therefore not authorized to execute an nttc under that section. The general service for resale deduction under Section 7-9-48 NMSA 1978 also does not apply because this deduction requires that the resale of the security services by S to T must be subject to gross receipts tax. Since S is taking the deduction under Section 7-9-52 NMSA 1978 this requirement in Section 7-9-48 NMSA 1978 cannot be met. W's receipts from providing security services to S are subject to gross receipts tax.

D. Example 3: Same facts

as in Example 3 except S does not enter into a subcontract with W. Instead, T amends the contract with S to provide security services for only eight of the construction sites and T enters into a separate contract with W to provide security services for the remaining two sites. So long as T provides nttcs to S and W, both security providers can take the construction related service deduction under Section 7-9-52 NMSA 1978.

[3.2.210.25 NMAC - N, XXX]

3.2.249.8 LEASED ITEMS USED ON A CONSTRUCTION PROJECT - OIL FIELD:

A. On or after January 1, 2013, receipts from the lease of construction equipment may be deducted from gross receipts tax if the leased items are used on a construction project and the requirements of Section 7-9-52.1 NMSA 1978 are met. The following are some examples of items that if leased to a person engaged in the construction business would be deductible under Section 7-9-52.1 NMSA 1978:

(1) drilling equipment, including derricks, blocks, substructures, draw-works, flooring, rotary tables, engines, mud pumps, pipe racks, tanks, doghouses, hoses, water and fuel lines, water well equipment, blowout preventers and other drilling equipment and tools;

(2) drill stems, drill collars, subs and kelly; and

(3) fishing tools.

B. Receipts from the lease of the above items that remain on the oil field after the completion of the construction project, once the well is operational, do not qualify for the deduction under Section 7-9-52.1 NMSA 1978.

[3.2.249.8 NMAC - N, XXX]

3.2.249.9 LEASE OF CONSTRUCTION EQUIPMENT:

A. Receipts from leasing construction equipment, with or without operators, to a person engaged in the construction business may be deducted from the lessor's gross receipts pursuant to Section 7-9-52.1 NMSA 1978.

B. Example 1: A is regularly engaged in the lease and rental of construction equipment. A enters into an agreement to lease a crane with an operator to a contractor engaged in the construction business to be used on a construction project. The contractor will direct all of the activity of the crane and operator on the construction site. A's receipts from the lease of the crane with an operator are receipts from leasing construction equipment pursuant to Section 7-9-52.1 NMSA 1978 and are deductible.

C. Example 2: X is a heating and air conditioning subcontractor on a construction project. X owns a crane which X regularly uses to lift equipment onto the roof of buildings on which X works. X's receipts for construction services includes payment for using the crane. X may deduct those receipts under Section 7-9-52 NMSA 1978. If, however, X agrees to lease the crane with an operator to the prime contractor for work unrelated to the subcontract, which work is performed at the direction of the prime contractor, X would not be able to deduct the receipts for the leasing of the crane under Section 7-9-52 NMSA 1978, but could deduct the receipts under Section 7-9-52.1 NMSA 1978 as receipts from the lease of construction equipment.

D. Example 3: C is engaged in the construction business. C hires S, a scaffolding-rental company, to deliver scaffolding to a specific construction project, erect the scaffolding, inspect the equipment daily for continued safety compliance, disassemble the scaffolding and transport it away from the construction site upon completion of the project. C may execute a nontaxable transaction certificate to S for the lease of the scaffolding pursuant to Section 7-9-52.1 NMSA 1978.

E. This version of 3.2.249.9 NMAC applies to transactions occurring on or after January 1, 2013.

[3.2.249.9 NMAC - N, XXX]

3.2.1.7 DEFINITIONS: The terms defined in [~~Section~~] 3.2.1.7 NMAC apply throughout [~~Section~~] 3.2 NMAC.

A. **Benefit:** A "benefit" is any consideration to either party. "Benefit" is not limited to profits, pecuniary gains, or any particular kind of advantage.

B. **Consideration:** "Consideration" is any benefit, interest, gain or advantage to one party, usually the seller, or any detriment, forbearance, prejudice, inconvenience, disadvantage, loss of responsibility, act or service given, suffered, or undertaken by the other party, usually the buyer.

C. **Detriment:** A "detriment" is a forbearance of either party of a right which the party is entitled to exercise or any consideration flowing from either party, not limited to payment of money or transfer of property.

D. **Financial corporations:**

(1) A financial corporation is any corporation primarily dealing in moneyed capital and in substantial competition with commercial banks.

(2) Example 1: FC is a corporation which is primarily engaged in the following activities: (a) buying and selling mortgages on real estate, (b) initiating mortgages on real estate and selling these mortgages, and (c) servicing mortgages. FC is a financial corporation because it is primarily dealing in moneyed capital and is in substantial competition with commercial banks.

(3) Example 2: IA is an insurance agency which, as an adjunct of its primary business, loans money to finance premiums. IA is not a financial corporation because it is not primarily dealing in moneyed capital and it is not in substantial competition with commercial banks.

(4) Example 3: A corporation which receives a commission on sales of money orders to its customers as an adjunct of its primary business is not a financial corporation within the meaning of Subsection C of Section 7-9-3 NMSA 1978 simply because it engages in this business activity.

(5) Example 4: A corporation which is engaged in the following activities is not a financial corporation because it is not primarily dealing in moneyed capital and is not in substantial competition with commercial banks:

(a) acting as an investment advisor to a mutual fund and others and receiving a fee for such services;

(b) acting as principal underwriter for the same mutual fund as in 1 above and receiving a fixed percentage of the selling price of the securities sold as a commission or fee; or

(c) issuing a weekly stock analysis report as an advisory service, receiving for this service payment in the form of subscription fees.

E. **Franchise:**

(1) A "franchise" is an agreement in which the franchisee agrees to undertake certain business activities or to sell a particular type of product or service in accordance with methods and procedures prescribed by the franchisor, and the franchisor agrees to assist the franchisee through advertising, promotion and other advisory services. The franchise usually conveys to the franchisee a license to use the franchisor's trademark or trade name in the operation of the franchisee's business.

(2) Example: Y, a pie company of Cambridge, Massachusetts, grants to X of Virden, New Mexico, the right to make pies according to their exclusive recipe and to operate Y Pie shops throughout New Mexico. The right to make the pies and operate the pie shops, whether granted for a "one-time" payment or for a continuing percentage of the proceeds of the shops, is a franchise. Therefore, the receipts of Y, from its granting of the franchise are subject to gross receipts tax.

F. **Computer-related terms:**

(1) "Computer software" means computer programming in whatever form or medium.

(2) "Custom software" means computer programming developed specifically at the order of another or for a specific purpose. "Custom software"

includes the modification of existing computer programming.

(3) "Packaged software" means computer programming embodied in electronic, electromagnetic or optical materials for transfer from one person to another, with or without explanatory materials, instructions or other programming and intended to be sold or licensed without modification to multiple buyers or users.

(4) "Software" means "computer software".

G. **Practitioner of the healing arts:** A "practitioner of the healing arts" is a person licensed to practice in this state medicine, osteopathic medicine, acupuncture and oriental medicine, dentistry, podiatry, optometry, chiropractic, nursing or similar medical services for human beings. The term also includes veterinarians licensed to practice in this state.

H. **Person engaged in the construction business:** A "person engaged in the construction business" is a person who performs construction services as defined in Section 7-9-3.4 NMSA 1978.

[12/5/69, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 12/29/89, 11/26/90, 11/15/96, 4/30/97, 1/15/98; 3.2.1.7 NMAC - Rn & A, 3 NMAC 2.1.7, 4/30/01; A, 12/30/03; A, XXX]

3.2.1.11 CONSTRUCTION

A. **Construction service as distinguished from other services.**

(1) The term "construction" is limited to the activities, or management of the activities, which are listed in Section 7-9-3.4 NMSA 1978 and which physically change the land or physically create, change or demolish a building, structure or other facility as part of a construction project.

(2) "Construction" does not include services that do not physically change the land or physically create, change or demolish a building, structure or other facility as part of a construction project, even though they may be related to a construction project. The fact that a service may be a necessary prerequisite or ancillary to construction or a construction project does not in itself make the service a construction service. Excluded from the meaning of "construction" are activities such as, but not limited to: hauling to or from the construction site [~~except as otherwise provided in Subsection C of Section 3.2.52.10 NMAC~~], maintenance work, landscape upkeep, the repair of equipment or appliances, laboratory work or accounting, architectural, engineering, surveying, traffic safety or legal services. Some of these activities may qualify as construction-related services; see Section 7-9-52 NMSA 1978.

~~[(3) "Construction" does not include leasing, such as renting or leasing equipment with or without an operator.~~

~~B. **Speculative builders.** A person is engaged in the construction business if that person constructs improvements on real property which the person owns and which improved property is held for sale in the ordinary course of business.~~

~~C.~~] B. **Construction includes.** Pursuant to Section 7-9-3.4 NMSA 1978 the term "construction" includes the painting of structures, the installation of sprinkler systems and the building of irrigation pipelines.

[~~D.~~] C. **Construction does not include.**

(1) [~~Pursuant to Section 7-9-3.4 NMSA 1978~~] The term "construction" does not include the installation of carpets or the installation of draperies, but see 3.2.209.25 NMAC.

(2) [~~A person engaged in the construction business, however, may deliver a Type 6 nontaxable transaction certificate for the purchase of carpets, draperies, or installed carpet or installed draperies to the seller.~~

~~(3) Even though receipts from selling carpet installation services or drapery installation services to a person engaged in the construction business are receipts from the sale of a service for resale, a person engaged in the construction business may deliver a Type 7 nontaxable transaction certificate for the purchase of carpet installation services or drapery installation services.~~] The term "construction", as defined in Section 7-9-3.4 NMSA 1978, does not include leasing or renting tangible personal property, such as construction equipment, with or without an operator but see Section 7-9-52.1 NMSA 1978 for transactions after January 1, 2013.

[~~E.~~] D. **Oil and gas industry construction.**

(1) "Construction", as this term is used in Section 7-9-3.4 NMSA 1978, includes the following activities related to the oil and gas industry:

(a) building and altering of gas compression plant facilities and pump stations, including: clearing of property sites; excavating for foundations; building and setting foundation forms; mixing, pouring, and finishing concrete foundations for buildings and plant equipment on foundations; fabricating and installing piping; installing electrical equipment, insulation, and instruments; erecting buildings; placing sidewalks, drives, parking areas; installing storage tanks; and dismantling equipment and reinstalling elsewhere;

(b) building of or extension of gas-gathering pipelines, including: connecting gathering lines to lease separators, fabricating and installing meter runs, digging trenches, beveling pipe, welding pipe, wrapping pipe, backfilling trenches, testing pipelines, fabricating and installing pipeline drips and installing conduit for pipelines crossing roads or railroads;

(c) building of or extension of product pipelines, including: building pressure-reducing stations; connecting pipelines to storage tanks, fabricating and installing valve assemblies, digging trenches, beveling pipe, welding pipe, wrapping pipe, laying pipe, backfilling trenches, testing pipelines and installing conduit for pipeline crossing roads or railroads;

(d) building secondary-recovery systems, including: excavating and building foundations, installing engines and water pumps, installing pipelines for water intake, installing pipelines for carrying pressured water to input wells, installing instruments and controls and erecting buildings;

(e) installing lease facilities, including: installing wellheads, flow lines, chemical injectors, separators, heater-treaters, tanks, stairways and walkways; building foundations; and setting pump units and engines, central power units and rod lines;

(f) demolishing pipelines, including: digging trenches to uncover pipelines, dismantling and removing drips and meter runs, backfilling trenches, tamping and smoothing right-of-way;

(g) increasing pipeline capacity, including: removing small pipelines and replacing with larger lines, and digging adjoining trenches and laying new pipelines;

(h) repairing plant, including: replacing tubing in atmospheric condensers, replacing plugged boiler tubing; removing cracked, broken or damaged portions of foundations and replacing anew; replacing compressors, compressor engines, or pumps; and regrouting and realigning compressors;

(i) drilling wells, including: drilling ratholes, excavating cellars and pits, casing crew services, cementing services, directional drilling, drill stem testing and fishing jobs in connection with drilling operations;

(j) general dirt work, including: building roads, paving with caliche or other surfacing materials; digging pits, trenches, and disposal ponds, building firewalls and foundation footing; and constructing pads from caliche or other materials.

(2) "Construction", as the term is used in Section 7-9-3.4 NMSA 1978, does not include the following activities related to the oil and gas industry:

(a) well servicing, including: acidizing and fracturing formations; pulling and rerunning rods or tubing; loading or unloading a well; shooting; scraping paraffin; steaming flow lines and tubing; inspecting equipment; fishing jobs, other than in connection with drilling operations; bailing cave-ins; reverse circulating and resetting packers;

(b) lease and plant maintenance,

including: cleaning; weed-control; preventive care of machinery, pipelines, gathering systems, and engines; tank cleaning; testing of flow lines by pressure or X-ray means; cleaning lines and tubing by acid treatment or mechanical means, or replacing and restoring machinery components;

(c) transporting equipment, including: transporting drilling rigs, rigging-up and rigging-down, and hauling water and mud;

(d) salvaging of materials from a "production unit", as defined in the Oil and Gas Emergency School Tax Act, such as: killing the gas pressure, removing casing heads, welding pull nipples on the casing, cutting or shooting casing strings, pulling casings from the well bore, cementing to fill the abandoned well or plug the well, filling the cellar, and welding steel pipe markers;

(e) rental of equipment such as: power tongs, blowout preventors, tanks, pipe racks, core barrels, integral parts of a drilling rig or integral parts of a circulation unit, for transactions after January 1, 2013, see Section 7-9-52.1 NMSA 1978;

(f) measuring, "logging" and surveying services in connection with the drilling of an oil or gas well are construction-related services as of January 1, 2013, see Section 7-9-52 NMSA 1978. "Logging" as that term is used in this subsection is a method of testing or measuring an oil or gas well by recording various aspects of the geological formations penetrated by the well.

[~~F.~~] E. **Construction includes prefabricated buildings; prefabricated versus modular buildings.**

(1) The sale of prefabricated buildings, whether constructed from metal or other material, is the sale of construction. A prefabricated building is a building designed to be permanently affixed to land and manufactured (usually off-site) in components or sub-assemblies which are then assembled at the building site. Prefabricated buildings are not designed to be portable [~~or relocatable~~] nor are they capable of being relocated.

(2) A portable building or a modular [~~relocatable~~] building is a building manufactured (usually off-site) which is designed to be [~~relocatable~~] moveable or is capable of being relocated and, when delivered to the installation site, generally requires only blocking, levelling and, in the case of modular [~~relocatable~~] buildings, joining of modules. For the purposes of Subsection F of [~~Section~~] 3.2.1.11 NMAC, neither portable buildings, modular [~~relocatable~~] buildings nor manufactured homes defined as vehicles by Section 66-1-4.11 NMSA 1978 are prefabricated buildings.

[~~G.~~] F. **Construction materials and services; landscaping.**

(1) Landscaping items, such as ornaments, rocks, trees, plants, shrubs, sod and seed, which are sold to a person engaged in the construction business, that are an integral part of the construction project, are construction materials. Persons who seed, lay sod or install landscape items in conjunction with a construction project are performing construction services.

(2) Receipts from selling landscaping items to, and from seeding, laying sod or installing landscape items for, persons engaged in the construction business may be deducted from gross receipts if the buyer delivers a nontaxable transaction certificate to the seller as provided in Section 7-9-51 and Section 7-9-52 NMSA 1978, respectively.

[~~H.~~] G. **Nontaxable transaction certificates.**

(1) Nontaxable transaction certificates are available from the department for persons who are [~~performing construction as set forth in Section 7-9-3.4 NMSA 1978 to issue~~] engaged in the construction business and performing activities, as set forth in Sections 7-9-3.4, 7-9-52 and 7-9-52.1 NMSA 1978 to execute to providers of construction materials, [~~and~~] construction services, construction-related services and lessors of construction equipment. See 3.2.201.11 NMAC for additional requirements on construction contractors to obtain nontaxable transaction certificates.

(2) Only persons who are licensed by the state of New Mexico as construction contractors may apply for and [~~use~~] execute nontaxable transaction certificates under the provisions of Sections 7-9-51 NMSA 1978, [~~and~~] 7-9-52 NMSA 1978, and 7-9-52.1 NMSA 1978, except that a person who performs construction activities as defined in Section 7-9-3.4 NMSA 1978 in the ordinary course of business, and who is exempt from the laws of the state of New Mexico requiring licensing as a contractor may [~~issue~~] apply for and execute such certificates.

[~~I.~~] H. **Fixtures.**

(1) Construction includes the sale and installation of "fixtures" such as kitchen equipment, library equipment, science equipment and other miscellaneous equipment installed so that it becomes firmly attached to the realty. Fixtures are considered to be items of tangible personal property which are necessary or essential to the intended use of a construction project and which are so firmly attached to the realty as to constitute a part of the construction project.

(2) Receipts from the sale of furniture, kitchen equipment, library shelves and other furniture or equipment sold on an assembled basis that does not become a "fixture" is a sale of tangible personal property and not construction.

[~~J.~~] I. **Construction materials; general.**

(1) The term "construction materials" means tangible personal property which is intended to become an ingredient or component part of a construction project.

(2) Tangible personal property intended ultimately to become an ingredient or component part of a construction project although not purchased for a specific project is nonetheless a construction material. *Example:* A government agency makes bulk purchases of asphalt which is stored by the agency for use in future road construction or repair projects. The asphalt is a construction material.

(3) Tools, equipment and other tangible personal property not designed or intended to become ingredients or component parts of a construction project are not construction materials if such materials accidentally become part of a construction project. *Example:* A workman accidentally drops a pair of gloves and a hammer into a form into which concrete is being poured. Because the gloves and the hammer are not intended to be included in the concrete structure, they are not construction materials.

[~~K.~~] J. **Meaning of "building".**

(1) As used in Section 7-9-3.4 NMSA 1978, the noun "building" means a roofed and walled structure designed for permanent use but excludes an enclosure so closely combined with the machinery or equipment it supports, houses or serves that it must be replaced, retired or abandoned contemporaneously with the machinery or equipment.

(2) A "building" includes the structural components integral to the building and necessary to the operation or maintenance of the building but does not include equipment, systems or components installed to perform, support or serve the activities and processes conducted in the building and which are classified for depreciation purposes as 3-year property, 5-year property, 7-year property, 10-year property or 15-year property by Section 168 of the Internal Revenue Code or, if the Internal Revenue Code is amended to rename or replace these depreciation classes, would have been classified for depreciation purposes as 3-year property, 5-year property, 7-year property, 10-year property or 15-year property but for the amendment.

(3) *Example:* A building may include any of the following equipment, systems or components:

(a) elevators and escalators used in whole or in part to move people;

(b) heating, cooling and air conditioning systems except for air conditioning and air handling systems and components, separately depreciated under Section 168, installed to meet temperature, humidity or cleanliness requirements for

the operation of machinery or equipment or the manufacture, processing or storage of products;

(c) electrical systems except for electrical systems and components, separately depreciated under Section 168, installed to power machinery or equipment operated as part of the activities and processes conducted in the building and not necessary to the operation or maintenance of the building; and

(d) plumbing systems except for plumbing systems and components, separately depreciated under Section 168, installed to perform, serve or support the activities and processes conducted in the building, such as for the handling, transportation or treatment of ingredients, chemicals, waste or water for a manufacturing or other process.

[9/29/67, 12/5/69, 3/9/72, 3/20/74, 7/26/76, 6/18/79, 11/8/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 3/19/92, 1/13/96, 11/15/96, 5/15/97, 9/15/97, 3.2.1.11 NMAC - Rn & A, 3 NMAC 2.1.11, 10/31/2000; A, 12/30/03; A, XXX]

3.2.1.16 GROSS RECEIPTS - REAL ESTATE AND INTANGIBLE PROPERTY

A. **Insurance proceeds**

(1) Receipts of an insured derived from payments made by an insurer pursuant to an insurance policy are not subject to the gross receipts tax. Such receipts are not receipts derived from the sale of property in New Mexico, the leasing of property employed in New Mexico, or the performance of a service.

(2) Example: ABC is an auto dealer in the business of selling new and used cars. In addition to selling cars, ABC also maintains a service garage with a large inventory of automobile parts. As part of its regular sales practice, ABC allows potential purchasers to test drive the cars. ABC carries automobile insurance which is applicable in the situation where the potential purchaser is test driving the car. When an accident occurs, even though some or all the parts used to repair the automobile are taken from ABC's inventory of parts and ABC does the actual repair work, payment received from the insurance company for the damaged automobile is not gross receipts. Such a payment is not received as consideration for selling property in New Mexico, leasing property employed in New Mexico, or for performing services. ABC is not liable for compensating tax on the value of the parts used or the labor.

[~~B. **Speculative housing sales**~~

~~(1) Receipts of a person in the business of constructing improvements on real property owned and sold in the ordinary course of that person's construction business do not include amounts retained by financial institutions as prepaid finance charges or discounts, if these amounts are not received by the real estate vendor. It is immaterial whether or not such amounts are included in the quoted real estate sales price.~~

~~(2) The receipts of such a person include all amounts actually paid over which are attributable to improvements constructed on the real property sold in the ordinary course of that person's construction business.~~

~~(3) The receipts of such a person also include any amounts deducted by a title-insuring company to cover title insurance, legal fees, escrow fees, real estate brokerage commissions, real estate taxes, principal and interest on construction loans, liens, and the like.~~

~~(4) Example 1: X, a speculative builder, sells improvements to Y who arranges to finance $43,000 with Z, a loan company. The loan company makes payment of $41,800 to X and designates the amounts retained as prepaid finance charges and/or discounts. X's gross receipts in this example are $41,800.~~

~~(5) Example 2: The same facts as Example 1 above are used except that the loan company Z made payment to a title insurance company, legal fees to a lawyer, escrow fees to a bank and also paid the real estate brokerage commission. These payments referred to are part of the gross receipts of the speculative builder and are not deductible under Subsection B of Section 3.2.1.16 NMAC, whether or not actually paid over to the speculative builder.~~

~~C.~~] B. **Receipts from sale of automotive service contracts**:

(1) "Automotive service contract" means an undertaking, promise or obligation of the promisor, for a consideration separate from the sale price of a motor vehicle, to furnish or to pay for parts and labor to repair specified parts of the covered motor vehicle only if breakdowns (failures) of those specified parts occur within certain time or mileage limits. The promisor's obligation is conditioned upon regular maintenance of the motor vehicle by the purchaser of the automotive service contract at the purchaser's expense. The automotive service contract may also obligate the promisor to reimburse the purchaser for certain breakdown related rental and towing charges. The automotive service contract may require the payment of a specified "deductible" or "co-payment" by the purchaser in connection with each repair.

(2) The receipts of a person from selling an automotive service contract are not gross receipts. The undertaking, promise or obligation of the promisor under the automotive service contract to pay for or to furnish parts and service if an uncertain future event (breakdown) occurs is not within the definition of property under Subsection J of Section 7-9-3 NMSA 1978. Since the receipts from selling an automotive service contract do not arise "from selling property in New Mexico, from leasing property employed in New Mexico or from performing services in New Mexico", the receipts are not gross receipts as defined in Section 7-9-3.5 NMSA 1978 and are not subject to the tax imposed by Section 7-9-4 NMSA 1978.

(3) The furnishing by the promisor of parts or labor or both to fulfill the promisor's obligation when a breakdown occurs is a taxable event.

[~~D.~~] C. **Receipts from insurance company under an automotive service contract program**: The receipts of a New Mexico automotive dealer from an insurance company are not taxable gross receipts if the payments by the insurance company are to reimburse the dealer, who is promisor under an automotive service contract as that term is defined in Subsection C of [~~Section~~] 3.2.1.16 NMAC, for all parts and labor furnished by the dealer under the contract or for parts and labor furnished by the dealer under the contract in an amount in excess of a specified reserve established by the dealer under an agreement with the insurance company. The receipt of the payments from the insurance company are not receipts from the sale of parts and labor but are payments to indemnify the dealer for the dealer's expense in fulfilling the dealer's obligation. The value of parts and labor furnished to make the repairs was subject to the gross receipts tax when the parts and labor were furnished to discharge the dealer's obligation as the promisor under the automotive service contracts.

[~~E.~~] D. **Gift certificates**:

(1) Receipts from the sale of gift certificates are receipts from the sale of intangible personal property of a type not included in the definition of "property" and, therefore, are not gross receipts.

(2) When a gift certificate is redeemed for merchandise, services or leasing, the person accepting the gift certificate in payment receives consideration, which is gross receipts subject to the gross receipts tax unless an exemption or deduction applies. The value of the consideration is the face value of the gift certificate.

(3) When a gift certificate is purchased during the time period set out in Laws 2005, Chapter 104, Section 25 subsequent redemption of the gift certificate for the purchase of qualified tangible personal property after that period is not deductible under Laws 2005, Chapter 104, Section 25.

(4) When a gift certificate is redeemed during the time period set out in Laws 2005, Chapter 104, Section 25 for the purchase of qualified tangible personal property, the receipts from the sale are deductible under Laws 2005, Chapter 104,

Section 25.

[~~F.~~] E. **Merchant discount and interchange rate fee receipts**: Bank receipts derived from credit and debit card merchant discounts and bank interchange rate fees are not gross receipts within the meaning of the Gross Receipts and Compensating Tax Act and therefore are not taxable.

[~~G.~~] F. **Prepaid telephone cards - "calling cards"**

(1) Receipts from the sale of an unexpired prepaid telephone card, sometimes known as a "calling card", are receipts from the sale of a license to use the telecommunications system and, therefore, are gross receipts and are not interstate telecommunications gross receipts. Receipts from selling an expired prepaid telephone card are receipts from the sale of tangible personal property and are gross receipts and are not interstate telecommunications gross receipts.

(2) Receipts from recharging a rechargeable prepaid telephone card are receipts from the sale of a license to use the telecommunications system and are gross receipts and are not interstate telecommunications gross receipts.

(3) Subsection F of 3.2.1.16 NMAC is retroactively applicable to transactions and receipts on or after September 1, 1998.

[3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 6/12/89, 6/28/89, 11/26/90, 2/1/95, 11/15/96, 9/15/98, 1/29/99; 3.2.1.16 NMAC - Rn & A, 3 NMAC 2.1.16, 4/30/01; A, 12/30/03; A, 8/15/05; A, XXX]

3.2.1.17 GROSS RECEIPTS - LEASING

A. **Leasing of property employed in New Mexico**:

(1) Receipts derived from the rental or leasing of property employed in New Mexico are subject to the gross receipts tax.

(2) Example 1: A is in the business of leasing heavy equipment used in construction projects. The receipts from the leasing of such equipment employed in New Mexico prior to January 1, 2013, are subject to the gross receipts tax. Receipts from similar transactions after January 1, 2013, may be deductible under Section 7-9-52.1 NMSA 1978.

(3) Example 2: Y, a New York corporation, leases four block-making machines to X who uses the machines in X's block-making business in New Mexico. The rental contract is signed in Nebraska. The receipts which Y receives from the rental of the equipment employed in New Mexico are taxable.

(4) Example 3: P corporation leases photocopying machines to Q, a state agency. The receipts of P corporation from leasing these machines to the state agency are subject to the gross receipts tax.

B. **Additional charges**

(1) Receipts derived from additional charges made in conjunction with the rental or leasing of property employed in New Mexico are subject to the gross receipts tax.

(2) Example 1: C owns and operates a business which leases gas cylinders. There is a clause in the lease whereby the lessee will be liable for an additional charge if the gas cylinders are kept past a specific date provided in the lease contract. Receipts from these penalties or demurrage charges for keeping the gas cylinders past the specified date provided are receipts from leasing property employed in New Mexico and are subject to the gross receipts tax.

(3) Example 2: D is in the business of leasing concrete forms which are employed in New Mexico. The terms of the lease agreement require that the property leased be returned to the lessor in the condition in which it was leased. Any receipts from charges for repairing and cleaning concrete forms returned to the lessor in a damaged condition, for any material used in repair of such forms, or from charges for the purchase price of forms which are not returned to the lessor, are receipts from leasing property employed in New Mexico and are subject to the gross receipts tax.

C. **Lease of license - franchise agreement**: Receipts derived from the lease of a license, such as a liquor license, or from a franchise agreement, are subject to the gross receipts tax.

D. **Multistate use of leased equipment**

(1) Where property is rented or leased for employment both within and outside New Mexico the renter or lessor will be subject to the gross receipts tax on that portion of the receipts which is derived from the renting or leasing of property employed in New Mexico.

(2) In order to determine the portion of the receipts which are subject to the gross receipts tax, the total receipts from the lease are to be multiplied by whichever of the following fractions more accurately reflects the receipts from the period of employment of the leased item inside New Mexico:

(a) the numerator is the total miles traveled by the leased items in New Mexico and the denominator is the total miles traveled by the leased items during the lease period; or

(b) the numerator is the total time the leased items were employed in New Mexico and the denominator is the total time of the lease period.

(3) The department will allow a person engaged in the business of leasing property employed both within and without New Mexico to use other methods of apportioning the receipts of such leasing activities upon showing that the other methods more accurately reflect the portion of employment of leased items within New Mexico.

(4) Example: B owns and operates a business located in Santa Fe, New Mexico, which rents or leases vehicles, airplanes, and mobile equipment. The items leased are employed both within and without New Mexico. B is subject to the gross receipts tax on that portion of the receipts which is from employment of the vehicles, airplanes, and mobile equipment within New Mexico.

E. **Leasing of property employed outside New Mexico**

(1) Receipts derived from the rental or leasing of property employed outside New Mexico are not subject to the gross receipts tax.

(2) Example: L, a resident of Hobbs, New Mexico, owns a sawmill in Wyoming which is leased to S for $3,000 per year. These receipts are not derived from selling property in New Mexico, leasing property employed in New Mexico, performing services outside of New Mexico the product of which is initially used in New Mexico, or performing services in New Mexico. These receipts are not includable in L's gross receipts.

F. **Use of vehicles in New Mexico**

(1) Receipts from the rental or leasing of vehicles, airplanes, or mobile equipment which are employed both within and outside New Mexico are subject to the gross receipts tax on that portion of the receipts which are from employment of the vehicles, airplanes, or mobile equipment within New Mexico.

(2) In order to determine the portion of receipts described in the above paragraph which are subject to the gross receipts tax, the total receipts from the lease are to be multiplied by whichever of the following fractions more accurately reflects the receipts from the period of employment of the leased item inside New Mexico:

(a) the numerator is the total miles traveled by the leased items in New Mexico and the denominator is the total miles traveled by the leased items during the period of lease; or

(b) the numerator is the total time the leased items were physically present in New Mexico and the denominator is the total time of the lease period.

(3) The department will allow a person engaged in leasing the above described items to use other methods of apportionment upon a showing that the other methods will more accurately reflect the period of employment of the leased item within New Mexico.

G. **Safe harbor lease -**

purchaser/lessor: A purchaser/lessor who enters into a qualified "safe harbor lease" transaction as defined in Section 168 of the Internal Revenue Code will be subject to the gross receipts tax on the receipts if the property being leased is located in New Mexico.

H. **Leasing computers:** Receipts from renting or leasing the use of computers or related equipment in New Mexico, on either a part-time or a full-time basis, are subject to the gross receipts tax.

[12/5/69, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.1.17 NMAC - Rn & A, 3 NMAC 2.1.17, 4/30/01; A, XXX]

3.2.1.18 GROSS RECEIPTS; SERVICES

A. **Receipts from performing a service in New Mexico.** Receipts derived from performing a service in New Mexico are subject to the gross receipts tax unless a specific exemption or deduction provided for in the Gross Receipts and Compensating Tax Act exists.

B. **Services performed both within and without New Mexico.** Receipts from services, other than research and development services and services subject to the Interstate Telecommunications Gross Receipts Tax Act, performed both within and without New Mexico are subject to the gross receipts tax on the portion of the services performed within New Mexico.

C. **Allocating receipts from selling services performed within and without New Mexico.**

(1) When a prime contractor performs services both within and without New Mexico, cost accounting records which reasonably allocate all costs to the location of the performance of the service shall be used to determine the amount of services performed in New Mexico. If adequate cost accounting records are not kept for the allocation of costs to specific locations, the receipts from performing such services shall be prorated based on the percentage of service actually performed within New Mexico. The percentage shall be calculated by dividing the time spent by the prime contractor in performing such services in New Mexico by the total contract time spent performing services everywhere. Other reasonable methods of prorating such services may be acceptable if approved by the department in advance of performing the services.

(2) Services subcontracted to third parties under a single contract by a prime contractor and used or consumed by the prime contractor in the performance of the contract shall be prorated by the prime contractor on the same basis, i.e., based either on allocated costs using cost accounting records or on the percentage of the total service actually performed within New Mexico by the prime contractor or other reasonable method approved by the department.

(3) If a subcontract service is actually a service purchased for resale, and all conditions of Section 7-9-48 NMSA 1978 are met and the subcontracted service is actually sold intact to the prime contractor's customer, the prime contractor may issue a Type 5 nontaxable transaction certificate to the subcontractor and the receipts from such subcontracted service will be deductible from the subcontractor's gross receipts.

(4) The subcontractor must use the same method of prorating the performance of services within and without New Mexico as used by the prime contractor.

(5) This subsection shall not apply to a contractor who is performing construction services.

D. **Expenses incurred outside New Mexico and allocated to operations in New Mexico.**

(1) General administrative and overhead expenses incurred outside New Mexico and allocated to operations in this state for bookkeeping purposes, costs of travel outside New Mexico, which travel was an incidental expense of performing services in New Mexico, employee benefits, such as retirement, hospitalization insurance, life insurance and the like, paid to insurers or others doing business outside New Mexico for employees working in New Mexico and other expenses incurred outside New Mexico which are incidental to performing services in New Mexico, all constitute the taxpayer's expenses of performing services in New Mexico.

(2) No provision of the Gross Receipts and Compensating Tax Act allows a deduction for expenses incurred in performing services to determine gross receipts subject to tax. Therefore, the total amount of money or reasonable value of other consideration derived from performing services in New Mexico is subject to the gross receipts tax.

E. **Receipts from performing services outside New Mexico.**

(1) Receipts from performing services, except research and development services, outside New Mexico are not subject to the gross receipts tax under the provisions of Section 7-9-13.1 NMSA 1978.

(2) *Example 1:* P, a resident of New Mexico, is an expert forest fire fighter. P's receipts from fighting forest fires outside New Mexico are not includable in P's gross receipts.

(3) *Example 2:* D is a data processing bureau located in Lone Tree, Iowa. X, a New Mexico accounting and bookkeeping firm, mails accounting data to D. D then processes this material into general ledgers, payroll journals and other journals and then returns this material by mail to X. The receipts of D are receipts from performing services entirely outside New Mexico and therefore are not subject to the gross receipts tax.

(4) *Example 3:* L, an Albuquerque attorney, is retained by a Colorado firm to negotiate and draw up oil and gas leases for lands in southern Colorado. To accomplish this objective, L goes to Pueblo, Colorado, and there negotiates and draws the leases. Receipts from the fee are not includable in L's gross receipts because the service was performed entirely outside the state of New Mexico.

F. **Sales of state licenses by nongovernmental entities.**

(1) Amounts retained by nongovernmental entities as compensation for services performed in selling state licenses are gross receipts.

(2) *Example:* G owns and operates a small grocery store in rural New Mexico which is located near a popular fishing area. As a convenience to the public, G sells New Mexico Game and Fish licenses. For its services in selling these licenses, G retains a small percentage of the total license fee. The amounts retained are gross receipts because they are receipts derived from services performed in New Mexico. G may not deduct the amounts retained pursuant to Section 7-9-66 NMSA 1978 which deals with commissions derived from the sale of tangible personal property not subject to the gross receipts tax. A New Mexico game and fish license is not tangible personal property pursuant to Subsection J of Section 7-9-3 NMSA 1978.

G. **Stockbrokers' commissions.** Gross receipts include commissions received by stockbrokers, located in New Mexico, for handling transactions for out-of-state as well as in-state residents.

H. **Attorneys' fees.** Regardless of the source of payment or the fact of court appointment, the fees of attorneys are subject to the gross receipts tax to the extent that their services are performed in this state.

I. **Directors' or trustees' fees.**

(1) The receipts of a member of a board of directors or board of trustees from attending a directors' or trustees' meeting in New Mexico are receipts derived from performing a service in New Mexico and are subject to the gross receipts tax.

(2) *Example:* X is on the board of directors of a New Mexico corporation and a Texas corporation. X attends directors' meetings in Texas and New Mexico. For each directors' meeting that X attends, X is paid a fee of $50.00. X is performing a service. The fee which X receives from performing this service in New Mexico is subject to the

gross receipts tax. The fee which X receives from performing the service in Texas is not subject to the gross receipts tax. However, the burden is on X to segregate receipts which are not taxable from those which are taxable.

(3) *Example:* Y is on the board of trustees of Z, a New Mexico electric cooperative organized under the provisions of the Rural Electric Cooperative Act. Y receives $85 a day for Y to attend Z's regular meetings in New Mexico, plus reimbursement for mileage to and from the meeting at the standard IRS rate. Y also receives $85 a day for Y to attend no more than one other meeting, conference or training inside or outside New Mexico within any one month, plus reimbursement of actual expenses, including hotel, transportation, tips and reasonable expenses for meals and entertainment. Y is performing a service. The fees and reimbursements Y receives for attending meetings, conferences and trainings in New Mexico are subject to gross receipts tax. The fees and reimbursements Y receives for attending meetings, conferences and trainings outside New Mexico are not subject to gross receipts tax.

(a) See Paragraph (1) of Subsection C of 3.2.1.19 NMAC regarding reimbursed expenditures.

(b) Y is not a volunteer as defined in Paragraph (2) of Subsection D of 3.2.1.19 NMAC because Y receives compensation for Y's services in addition to reimbursement of Y's out-of-pocket expenses incurred in the performance of Y's services.

J. **Anesthetists' fees.**

(1) The receipts of a nonemployee anesthetist from anesthetic services performed for a surgeon are subject to the gross receipts tax.

(2) The receipts of an anesthetist from the performance of this service for a surgeon may be deducted from gross receipts if the surgeon resells the service to the patient and delivers a nontaxable transaction certificate to the anesthetist. The surgeon delivering the nontaxable transaction certificate must separately state the value of the service purchased in the charge for the service on its subsequent sale. The subsequent sale must be in the ordinary course of business and subject to the gross receipts tax.

(3) *Example:* A is an anesthetist who is employed by a hospital and also performs services for and receives compensation from a surgeon who is not associated with the hospital. The surgeon does not consider the anesthetist to be an employee and does not withhold income or other taxes from the anesthetist's compensation. Although the surgeon may exercise some control over the services performed by the anesthetist, the surgeon relies on the anesthetist's training and experience to accomplish the result desired. The receipts of the anesthetist from this service performed are subject to the gross receipts tax.

K. **Athletic officials.**

(1) Receipts from refereeing, umpiring, scoring or other officiating at school events sanctioned by the New Mexico activities association are exempt from gross receipts tax pursuant to Section 7-9-41.4 NMSA 1978.

(2) Receipts of a referee, umpire, scorer or other similar athletic official from umpiring, refereeing, scoring or officiating at a sporting event located in New Mexico that is not sanctioned by the New Mexico activities association, are receipts derived from performance of a service and are subject to the gross receipts tax. Such receipts will not be exempted from the gross receipts tax as "wages" unless the umpires, referees, scorers and other athletic officials demonstrate to the department that such receipts are derived from an employment relationship whereby they are employees within the meaning of 3.2.105.7 NMAC.

L. **Racing receipts.**

(1) Unless the receipts are exempt under Section 7-9-40 NMSA 1978:

(a) the receipts of vehicle or animal owners from winning purse money at races held in New Mexico are receipts from performing services in New Mexico and are subject to the gross receipts tax if any charge is made for attending, observing or broadcasting the race.

(b) receipts of vehicle drivers, animal riders and drivers and other persons from receiving a percentage of the owner's purse are receipts from performing services in New Mexico and are subject to the gross receipts tax, unless the person receiving the percentage of purse money is an employee, as that term is defined in [~~Section~~] 3.2.105.7 NMAC, of the owner.

(2) Where there is an agreement between the driver, rider or other person and the owner for distribution of the winning purse, then only the amount received pursuant to the agreement is gross receipts of the driver, rider or other person receiving the distribution.

M. **Advertising receipts of a newspaper or broadcaster.**

(1) The receipts of a New Mexico newspaper or a person engaged in the business of radio or television broadcasting from performing advertising services in New Mexico do not include the customary commission paid to or received by a nonemployee advertising agency or a nonemployee solicitation representative, when said advertising services are performed pursuant to an allocation or apportionment agreement entered into between them prior to the date of payment.

(2) Receipts of a New Mexico newspaper or a person engaged in the business of radio or television broadcasting from the sale of advertising services to an advertising agency for resale may be deducted from gross receipts if the advertising agency delivers a nontaxable transaction certificate to the newspaper or the person engaged in the business of radio or television broadcasting. The subsequent sale must be in the ordinary course of business and subject to the gross receipts tax, or the advertising agency will be subject to the compensating tax on the value of the advertising service at the time it was rendered. This version of Paragraph (2) of Subsection M of [~~Section~~] 3.2.1.18 NMAC applies to transactions occurring on or after July 1, 2000.

N. **Advertising space in pamphlets.** Receipts from selling advertising service to New Mexico merchants in a pamphlet printed outside New Mexico and distributed wholly inside New Mexico are receipts from performing an advertising service in New Mexico. Such receipts are subject to the gross receipts tax.

O. **Billboard advertising.** Receipts derived from contracts to place advertising on outdoor billboards located within the state of New Mexico are receipts from performing an advertising service in New Mexico. Such receipts are subject to the gross receipts tax, regardless of the location of the advertiser.

P. **Day care centers.**

(1) Receipts from providing day care are receipts from performing a service and are subject to the gross receipts tax.

(2) Receipts from providing day care for children in a situation where a commercial day care center provides day care for the children and the expenses of the care for some of these children is paid for by the state of New Mexico are subject to the gross receipts tax.

(3) Receipts from providing day care for children in a situation where a person provides day care for children in a residence and the care for all these children is paid for by the state of New Mexico are subject to the gross receipts tax.

(4) Receipts from providing day care for children in a situation where a person provides day care for children in the children's home and the care for all of these children is paid for by the state of New Mexico are subject to the gross receipts tax.

Q. **Child care.**

(1) Receipts derived by a corporation for providing child care facilities for its employees are subject to the gross receipts tax on the amount received from its employees.

(2) *Example:* The X corporation operates a licensed child care facility to accommodate dependent children of its employees. In order to defray a portion of the cost of the facility, the corporation charges each employee two dollars ($2.00)

per child per week for the use of the facility. All receipts from the two-dollar charge per child per week are subject to the gross receipts tax.

R. **Service charges; tips.**

(1) Except for tips, receipts of hotels, motels, guest lodges, restaurants and other similar establishments from amounts determined by and added to the customer's bill by the establishment for employee services, whether or not such amounts are separately stated on the customer's bill, are gross receipts of the establishment.

(2) A tip is a gratuity offered to service personnel to acknowledge service given. An amount added to a bill by the customer as a tip is a tip. Because the tip is a gratuity, it is not gross receipts.

(3) Amounts denominated as a "tip" but determined by and added to the customer's bill by the establishment may or may not be gross receipts. If the customer is required to pay the added amount and the establishment retains the amount for general business purposes, clearly it is not a gratuity. Amounts retained by the establishment are gross receipts, even if labeled as "tips". If the customer is not required to pay the added amount and any such amounts are distributed entirely to the service personnel, the amounts are tips and not gross receipts of the establishment.

(4) *Examples*:

(a) Restaurant R has a policy of charging parties of six or more a set percentage of the bill for food and drink served as a tip. If a customer insists on another arrangement, however, the set amount will be removed. R places all amounts collected from the set tip percentage into a pool which is distributed to the service staff at the end of each shift. The amounts designated as tips and collected and distributed by R to the service staff, are tips and not gross receipts. If R retains any amounts derived from the set tip percentage, the amounts retained are gross receipts.

(b) Hotel H rents rooms for banquets and other functions. In addition to the rental fee for the room, H also charges amounts for set-up and post-function cleaning. H retains these amounts for use in its business. These amounts are gross receipts. They are gross receipts even if H denominates them as "tips".

S. **Real estate brokers.**

(1) Receipts of a person engaged in the construction business from the sale of the completed construction project include amounts which the person has received and then paid to a real estate broker. The total receipts from the sale of the construction project are subject to the gross receipts.

(2) Receipts of a real estate broker from the performance of services for a person engaged in the construction business may not be deducted from gross receipts pursuant to Section 7-9-52 NMSA 1978.

(3) Receipts of a real estate broker from the performance of services for a person engaged in the construction business that are attributable to improvements constructed on real property that are taxable under Subsection A of Section 7-9-53 NMSA 1978 may be deducted pursuant to Section 7-9-66.1 NMSA 1978.

T. **Entertainers.** The receipts of entertainers or performers of musical, theatrical or similar services are subject to the gross receipts tax when these services are performed in New Mexico.

U. **Managers or agents of entertainers.** Commissions received by managers or agents of entertainers for the managers' or agents' services in New Mexico are subject to the gross receipts tax.

V. **Water utilities; installation of water taps and pipes.** The receipts of a water utility from providing a "tap" to a water main and installing a pipe from the water main to a meter which it provides are subject to the gross receipts tax. However, if the utility is owned or operated by a county, municipality or other political subdivision of the state of New Mexico, its receipts from providing a "tap" to a water main and installing a pipe from a water main to a meter which it also provides are exempted from the gross receipts tax.

W. **Utilities; installation charges.**

(1) The receipts of a utility from installation charges are subject to the gross receipts tax. However, if the utility is owned or operated by a county, municipality or other political subdivision of the state of New Mexico, its receipts from installation charges are exempt from the gross receipts tax.

(2) The receipts of a private water utility from providing a "tap" to a water main and installing a pipe from the water main to a meter which it provides are subject to the gross receipts tax.

(3) Receipts of a private electric utility from fees for changing, connecting or disconnecting electricity of customers, whether or not these services are required because of nonpayment of bills by a customer, are subject to the gross receipts tax.

X. **Construction on Indian reservations or pueblos.** The receipts of a non-Indian from construction services, as defined in Section 7-9-3.4 NMSA 1978 and regulations thereunder, performed on an Indian reservation or pueblo are subject to the gross receipts tax unless the imposition of the gross receipts tax is preempted by federal law.

Y. **Star route contractors.** Receipts of a person holding a contract for transportation of United States mail, as a "Star Route Contractor", from points within New Mexico to other points within New Mexico and to points outside of New Mexico, are subject to the gross receipts tax on that portion of the receipts from transportation from a point within New Mexico to a point within New Mexico. See Paragraph (2) of Subsection B of [~~Section~~] 3.2.55.10 NMAC for deducting receipts from the portion in interstate commerce.

Z. **Racetrack operators.** Receipts of operators of racetracks other than horse racetracks, from gate admission fees and entrance fees paid by drivers are subject to the gross receipts tax. Any portion of these fees paid out by the operator as prizes are not exempt or deductible since the payments are part of the operator's cost of doing business.

AA. **Data access charges.** Receipts from fees or charges made in connection with property owned, leased or provided by the person providing the service are subject to the gross receipts tax when the information or data accessed is utilized in this state.

BB. **Specialty software package.** [Repealed]

CC. **Receipts from telephone or telegraph services.** Receipts derived from telephone or telegraph services originating or terminating in New Mexico and billed to an account or number in this state are receipts from performing services in New Mexico and are subject to the gross receipts tax unless exempt under Section 7-9-38.1 NMSA 1978.

DD. **Allied company underwriting automotive service contracts.** When a New Mexico automotive dealer pays an entity which is allied or affiliated with that dealer (allied company) to undertake all of the dealer's obligations under automotive service contracts as that term is defined in Subsection C of [~~Section~~] 3.2.1.16 NMAC on which the dealer is promisor, the undertaking of the allied company does not involve the sale of property in New Mexico or the lease of property employed in New Mexico. The undertaking principally involves an obligation of the allied company to indemnify the dealer by paying the dealer for furnishing parts and labor to fulfill the dealer's obligation to furnish the parts and labor. However, the undertaking also involves the performance of services by the allied company for the dealer since the allied company undertakes to handle the claims of automotive service contract purchasers and otherwise perform the dealer's task under the contract. Absent a showing of a different value by the allied company or the department, 7.5 percent of the contract amount paid by the dealer to the allied company will be treated as consideration received for services performed in New Mexico.

EE. **Custom software.**

(1) Except as otherwise provided

in Subsection EE of [~~Section~~] 3.2.1.18 NMAC, receipts derived by a person from developing custom software are receipts from performing a service.

(2) When custom software is developed by a seller for a customer but the terms of the transaction restrict the customer's ability without the seller's consent to sell the software to another or to authorize another to use the software, the seller's receipts from the customer are receipts from the performance of a service. The seller's receipts from authorizing the customer's sublicensing of the software to another person are receipts from granting a license. The seller's receipts from authorizing the use by another person of the same software are receipts from granting a license to use the software.

FF. **Check cashing is a service.** Receipts from charges made for cashing checks, money orders and similar instruments by a person other than the person upon whom the check, money order or similar instrument is drawn are receipts from providing a service, not from originating, making or assuming a loan. Such charges are not interest.

GG. **Receipts of collection agencies.**

(1) The fee charged by a collection agency for collecting the accounts of others is gross receipts subject to the gross receipts tax, regardless of whether the receipts of the client are subject to gross receipts tax and regardless of whether the agency is prohibited by law from adding its gross receipts tax amount to the amount collected from the debtor.

(2) *Example 1:* X is a cash basis taxpayer utilizing the services of Z collection agency for the collection of delinquent accounts receivable. From its New Mexico offices, Z collects from X's New Mexico debtors in the name of X, retains a percentage for its services and turns over the balance to X. The percentage retained by Z is its fee for performing services in New Mexico. The fee is subject to the gross receipts tax. It makes no difference that federal law prohibits Z from passing the cost of the tax to the debtor by adding it to the amount to be collected. X's gross receipts include the full amount collected by Z.

(3) Amounts received by collection agencies from collecting accounts sold to the collection agency are not gross receipts.

(4) *Example 2:* X, a cash basis taxpayer, sells its delinquent accounts receivable to Z, a collection agency, for a percentage of the face amount of the accounts. X's gross receipts include the full amount of the receivables, excluding any time-price differential. The amount subsequently collected by Z from those accounts, however, is not subject to gross receipts tax because the amount is not included within the definition of gross receipts. In this situation Z is buying and selling intangible property of a type not included within the definition of property in Subsection J of Section 7-9-3 NMSA 1978.

HH. **Commissions of independent contractors when another pays gross receipts tax on the receipts from the underlying transaction.**

(1) Commissions and other consideration received by an independent contractor from performing a sales service in New Mexico with respect to the tangible or intangible personal property of other persons are gross receipts whether or not the other person reports and pays gross receipts tax with respect to the receipts from the sale of the property. This situation involves two separate transactions. The first is the sale of the property by its owner to the customer and the second is the performance of a sales service by the independent contractor for the owner of the property. The receipts from the sale of the property are gross receipts of the person whose property was sold. Receipts, whether in the form of commissions or other remuneration, of the person performing a sales service in New Mexico are gross receipts of the person performing the sales service.

(2) *Example 1:* S is a national purveyor of tangible personal property. S has stores and employees in New Mexico. S also has catalogue stores in less populated parts of New Mexico. Catalogue stores maintain minimal inventories; their primary purpose is to make S's catalogues available to customers, to take orders of merchandise selected from the catalogues, to place the orders with S and to provide general customer service. The catalogue stores are operated by independent contractors and not by S. S pays the contractors commissions based on the orders placed. In charging its customers, S charges the amount shown in the catalogue and does not add any separate amount to cover the cost of the contractors' commissions. S pays gross receipts tax on its receipts from the sale of catalogue merchandise. The contractors contend that the cost of their selling services is included in the amount S charges for its merchandise and so their commissions are not gross receipts. The contention is erroneous. The contractors have receipts from performing a service in New Mexico; it is immaterial that S paid the amount of gross receipts tax S owed on S's receipts. See, however, the deduction at Subsection B of Section 7-9-66 NMSA 1978.

(3) *Example 2:* M is a nationwide, multi-level sales company with presence in New Mexico. M sells products to households mainly through a network of individual, independent contractors. The network of sellers is controlled by one or more sets of individuals, also independent contractors, who train and supervise the individuals selling the merchandise; these supervisory contractors may also sell merchandise. The sellers display, promote and take orders for M's products. Payment for orders are sent to M along with the orders. M ships the merchandise directly to the final customers. M has agreed to, and does, pay the gross receipts tax on the retail value of the merchandise sold, whether sold by M or one of the independent contractors. Based on the volume and value of merchandise sold, M pays both the selling and supervisory independent contractors a commission. The commissions received by the independent contractors engaging in business in New Mexico with respect to merchandise sold in New Mexico are gross receipts subject to the gross receipts tax. The commissions are receipts from performing a service in New Mexico. The fact that M pays gross receipts tax on M's receipts from the sale of the property is immaterial in determining the liability of the independent contractors.

(4) Commissions and other consideration received by an independent contractor from performing a sales service in New Mexico with respect to a service to be performed by other persons are gross receipts whether or not the other person reports and pays gross receipts tax with respect to the receipts from the performance of the underlying service. This situation involves two transactions. The first is the performance of the underlying service by the other person for the customer and the second is the performance of the sales service by the independent contractor for the performer of the underlying service. The receipts from the performance of the underlying service for the customer are gross receipts of the person performing that service. Receipts, whether in the form of commissions or other remuneration, of the person performing the sales service are gross receipts of the person performing the sales service.

(5) *Example 3*: P is the publisher of a magazine published in New Mexico. P enters into arrangements with independent contractors to solicit ads to be placed in P's publication. P pays each contractor a percentage of the billings for the ads placed by the contractor as a commission. The independent contractors claim that they owe no gross receipts tax with respect to ads solicited in New Mexico because P has paid gross receipts tax on P's advertising revenues. The contractors are incorrect. There are two transactions in this situation, P's service of publishing advertisements and the contractors' service of soliciting ads for P. The fact that P paid the amount of gross receipts tax due on P's advertising revenues is immaterial regarding the contractors' gross receipts tax obligations on their receipts.

(6) If the receipts from the underlying sale of the tangible property

are exempt or deductible, the commission received by an independent contractor from selling the tangible property of another may be subject to the deduction provided by Section 7-9-66 NMSA 1978.

II. **Receipts from winning contest.**

(1) Receipts of a contestant from winning purse money in a rodeo or an athletic game, match or tournament held in New Mexico are gross receipts from performing services if any charge is made for attending, observing or broadcasting the event. Such receipts are subject to the gross receipts tax unless an exemption or deduction applies. Where the contestant is a team and there is an agreement among the team members governing distribution of the purse money, then only the amount received by each team member pursuant to the agreement is gross receipts of the team member.

(2) Subsection II of 3.2.1.18 NMAC does not apply to receipts exempt under Section 7-9-40 NMSA 1978 nor does it apply to activities that are primarily or solely gambling.

[9/29/67, 12/5/69, 3/3/71, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 3/16/79, 6/18/79, 11/20/79, 4/7/82, 1/6/84, 5/4/84, 10/16/84, 4/2/86, 10/21/86, 6/28/89, 11/26/90, 11/15/96, 1/31/97, 4/30/97; R, 3 NMAC 2.1.18.28, 4/30/97; 3 NMAC 2.1.18.31, 4/30/97; 10/31/97, 7/31/98; R, 4/30/99, 11/15/99, 3.2.1.18 NMAC - Rn & A, 3 NMAC 2.1.18, 10/31/2000; A, 5/31/02; A, 12/30/03; A, 3/15/10; A, 10/15/10; A, XXX]

3.2.10.13 CONSTRUCTION PROJECTS OCCUPIED OR LEASED PRIOR TO SALE:

A. A person engaged in the construction business who purchases construction materials, [~~and~~] construction services, construction-related services or who leases construction equipment using nontaxable transaction certificates (nttcs) provided by the department for use under Sections 7-9-51, [~~and~~] 7-9-52 and 7-9-52.1 NMSA 1978 is liable for the compensating tax on the value of the materials and services purchased at the time when the construction project is initially leased or otherwise occupied prior to the sale. It is immaterial that the construction project is leased to enhance its value for sale as is the case with so-called income producing property.

B. Example 1: Y is a company which constructs office buildings for sale to investors as income producing property. Y has issued [~~nontaxable transaction certificates~~] nttcs to material suppliers and subcontractors. Upon completion of the building, Y leases office space to tenants in order to enhance the salability of the building. Y is liable for the compensating tax at the time it leases the first office.

C. Example 2: Z is building an apartment complex consisting of five separate buildings with twenty apartments in each building. Z begins renting apartments in each building as the building is completed. If Z issued [~~nontaxable transaction certificates~~] nttcs to purchase construction materials and construction services for incorporation into these apartment buildings, Z will be liable for compensating tax on the value of the materials and services purchased for each building when any apartment in the building is rented. The rental of the apartments is a conversion to use by Z. When Z subsequently sells any or all of the five buildings, the compensating tax previously paid by Z on construction materials and construction services which became an ingredient or component part of each building may be credited against the gross receipts tax due on the sale.

D. Example 3: R is a homebuilder who typically sells the homes he builds either prior to the start of construction, or on a speculative basis prior to the completion of the home. R has executed nttcs to material suppliers and subcontractors for a specific home. Upon completion of the home, R is unable to find a buyer, and decides to retain title to the home and use it as his personal home or rent the home to a third party until a buyer can be found. R is liable for the compensating tax on the value of the construction materials, construction services and construction-related services purchased with the nttcs at the time the home is initially rented or occupied by the homebuilder prior to the sale.

[7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96, 3.2.10.13 NMAC - Rn & A, 3 NMAC 2.7.13, 4/30/01; A, XXX]

3.2.201.8 POSSESSION AND DELIVERY OF NONTAXABLE TRANSACTION CERTIFICATES - TYPES OF CERTIFICATES:

A. With respect to receipts and transactions [~~occurring prior to July 1, 1992 or after June 30, 1997~~] deductible under the Gross Receipts and Compensating Tax Act:

(1) The taxpayer should be in possession of all nontaxable transaction certificates (nttcs) at the time the deductible transaction occurs.

(2) The taxpayer must be in possession of and have available for inspection all nttcs for the period of an audit within 60 days of notice by the department requiring such possession. This notice may be sent out or delivered no earlier than the commencement of an audit of the taxpayer claiming the deduction.

(3) An nttc acquired by the taxpayer after the 60 days following notice have expired will not be honored by the department for the period covered by the audit.

(4) An nttc executed using the department's online system, and that is recorded on the online system, will be considered to be in the possession of the taxpayer to whom the nttc has been executed.

[~~B. With respect to receipts and transactions occurring on or after July 1, 1992 and prior to July 1, 1997, the taxpayer is required to possess the appropriate nontaxable transaction certificate by the time the return is due for receipts from the transaction, except as otherwise provided herein. A certificate received after that time does not substantiate the deduction. The taxpayer must demonstrate possession of all certificates at the commencement of an audit. In the alternative, upon receipt of a notice requiring possession of the certificates, the taxpayer has sixty days to demonstrate that the taxpayer did in fact possess the certificates at the time the receipts were required to be reported. In the case where a notice requiring possession of the certificates has been given prior to July 1, 1997, demonstration that the certificates were possessed at the time the audit commenced or the notice was received is not adequate. In the case where notice requiring possession of the nttcs expired on or after July 1, 1997, the taxpayer must be in possession of and have available for inspection all nttcs for the period of an audit within 60 days of notice by the department requiring such possession.~~

~~C.~~] B. An audit of such a taxpayer commences when one of the following occurs:

(1) a department auditor physically gives a dated letter of introduction which states the auditor is commencing an authorized audit of the taxpayer or states the auditor requires the production of the taxpayer's books and records for examination; or

(2) a department employee begins an authorized office examination of files, books or records pertaining to the taxpayer, provided that the taxpayer or the taxpayer's representative is informed reasonably promptly by letter or in person that an audit has commenced.

[~~D. The department issues different types of nttcs. Each type is of limited usage and relates to a particular deduction allowed by possession of that certificate. An nttc is valid only if it contains the information and is in a form prescribed by the department. All other types of proof of deductibility are invalid and will not be accepted by the department, unless the deduction provision explicitly permits other proof.~~]

C. The department issues different types of nttcs. Each type is of limited usage and relates only to one or more particular deductions. An nttc is not valid

if it does not contain the information or is not in a form prescribed by the department. For a deduction that requires possession of the appropriate nttc, other types of proof of deductibility are invalid and will not be accepted by the department, unless other proof is permitted explicitly by the deduction or another provision of the Gross Receipts and Compensating Tax Act with respect to that deduction.

[~~E.~~] D. The taxpayer need be in possession of only one nttc of the type required by the department from each buyer or lessee in order to claim the particular deduction allowed by that type of nttc. A taxpayer need be in possession of only one nttc of the type required by the department in order to claim a particular deduction from a buyer which has several places of business, provided the buyer is operating under only one department identification number.

[~~F.~~] E. Nothing shall prevent the department from changing the substance, form or type of nttcs to be used. Nothing shall prevent the department from changing the form of notification requiring the possession of nttcs.

[9/29/67, 12/5/69, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 9/20/93, 11/15/96, 4/30/99; 3.2.201.8 NMAC - Rn, 3 NMAC 2.43.1.8, 5/31/01; A, XXX]

3.2.201.11 CONSTRUCTION CONTRACTORS:

A. Any person applying to execute nontaxable transaction certificates (nttcs) related to [~~construction as defined in Section 7-9-3 NMSA 1978~~] deductions found under Sections 7-9-51, 7-9-52 or 7-9-52.1 NMSA 1978 must indicate the applicant's New Mexico contractor's license number or furnish proof that no contractor's license is required by the construction industries division of the regulations and licensing department in order to engage in one of the construction activities listed in 7-9-3.4 NMSA 1978. Failure to comply with [~~Section~~] 3.2.201.11 NMAC will result in denial of the requested certificates.

B. A person [~~performing construction services~~] engaged in the construction business who makes any false or misleading representations in any material respect in an application for nttcs may become subject to the penalties imposed by Section 7-1-73 NMSA 1978 as well as other penalties, civil or criminal, prescribed in the Tax Administration Act. False or misleading representations include, but are not confined to:

(1) indicating a contractor's license number on the application which is not issued to the applicant or which cannot lawfully be used by the applicant;

(2) applying for nttcs which someone other than the applicant will execute; or

(3) furnishing false or misleading documentation that a contractor's license is not required of the applicant by the construction industries division.

C. Any person who has previously applied for and been issued nttcs related to construction as defined in Section [~~7-9-3~~] 7-9-3.4 NMSA 1978, under circumstances wherein the person would not have been entitled to obtain such certificates pursuant to [~~Section~~] 3.2.201.11 NMAC, will be assessed gross receipts or compensating tax, as appropriate, based on the representations actually made in the application for nttcs.

D. Any person engaged in the [~~business of construction, as defined by Section 7-9-3.4 NMSA 1978, is presumed to be engaged solely in the business of construction and~~] construction business is presumed not to be engaged in reselling services other than construction services, or, on or after January 1, 2013, construction-related services, in the ordinary course of business. Except as provided in Subsection E of this section, this person will not be issued [~~nontaxable transaction certificates (nttcs)~~] nttcs other than those appropriate for the deductions under Sections 7-9-51, [~~and~~] 7-9-52 and 7-9-52.1 NMSA 1978.

E. A person who can demonstrate to the department's satisfaction that the person is engaged in the [~~business of construction and~~] construction business and also in the business of selling property other than construction materials or performing or selling one or more services, [~~such as engineering or architectural design,~~] that are not construction services or, on or after January 1, 2013, construction-related services, may qualify for and be issued nttcs in addition to those appropriate for the deductions under Sections 7-9-51, [~~and~~] 7-9-52 and 7-9-52.1 NMSA 1978. The additional types of nttc may be executed by the person only when the person is acquiring tangible personal property other than construction material, [~~or~~] a service other than a construction service or, on or after January 1, 2013, a construction-related service, in a manner meeting the conditions for execution of the additional type of nttc. In determining whether the person engaged in the construction business is engaged in a business in addition to the construction business, the department will consider these factors:

(1) whether the person possesses, when possession is required, a current license to sell or lease the nonconstruction property or to perform or sell the nonconstruction service;

(2) whether the person has entered into a contract requiring the sale or lease of the nonconstruction property or the performance or sale of the nonconstruction service;

(3) whether the person holds himself out to be in the business; and

(4) other factors deemed appropriate by the secretary.

[7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 9/20/93, 11/15/96, 4/30/99; 3.2.201.11 NMAC - Rn, 3 NMAC 2.43.1.11 & A, 5/31/01; A, 11/30/05; A, XXX]

3.2.206.12 NONCONSTRUCTION SERVICES [~~NOT RESOLD BY~~] SOLD TO CONSTRUCTION CONTRACTORS:

A. Prior to January 1, 2013, any person engaged solely in the business of construction[~~, as defined by Section 7-9-3.4 NMSA 1978,~~] is not engaged in reselling services other than construction services in the ordinary course of business and may not [~~issue~~] execute a nontaxable transaction certificate (nttc) to purchase services for resale in connection with the construction business under the provisions of Section 7-9-48 NMSA 1978.

B. On or after January 1, 2013, any person engaged in the construction business who purchases construction-related services as defined in Section 7-9-52 NMSA 1978 and is engaged in reselling those construction-related services may execute an nttc to support the deduction under Section 7-9-52 NMSA 1978.

[3/11/88, 11/26/90, 11/15/96; 3.2.206.12 NMAC - Rn, 3 NMAC 2.48.12 & A; 5/31/01; A, 11/30/05; A, XXX]

3.2.210.8 [~~INDIRECT SERVICES ARE NOT CONSTRUCTION SERVICES~~]

~~A. Indirect services, such as accounting, architectural, engineering, drafting, bid depository services and plan room services are not construction services within the definition of construction under Section 7-9-3 NMSA 1978.~~

~~B. Example 1: K is a surveying company that contracts with C, a contractor, to survey the site. K incorrectly maintains that it is selling a construction service to C and that its receipts are deductible. Surveying and related services other than construction staking are not included as construction under the definition of construction under Section 7-9-3 NMSA 1978. Therefore, they are not construction services as that term is used in Section 7-9-52 NMSA 1978.~~

~~C. Example 2: E, an excavator, contracts with B, a prime contractor, to dig the trenches for the water and sewer lines from the city mains to the building site in connection with a building project. E is performing a construction service that is immediately adjacent to the project and is therefore entitled to the deduction providing B delivers~~

~~a nontaxable transaction certificate.~~] **GENERAL BUSINESS SERVICES ARE NOT CONSTRUCTION SERVICES OR CONSTRUCTION-RELATED SERVICES:**

A. General business services, such as accounting, legal services, real estate brokering, telecommunications and plan room services are not construction services within the definition of construction under Section 7-9-3.4 NMSA 1978 nor are they construction-related services as defined in Section 7-9-52 NMSA 1978. Receipts from performing these types of services to a construction contractor are subject to gross receipts tax.

B. Example 1: K is a law firm that contracts with C, a contractor, to provide legal services. K maintains that it is selling a legal service to C that is necessary for the completion of the construction project and that its receipts should not be subject to gross receipts tax. Legal services are not included under the definition of construction under Section 7-9-3.4 NMSA 1978 or under the definition of construction-related services under Section 7-9-52 NMSA 1978. There is no deduction available for K's receipts from providing legal services to C.

C. Example 2: C provides B with telecommunications services through which B can maintain contact with B's construction crew working at a remote site. C's receipts from this service are not deductible under Section 7-9-52 NMSA 1978.

D. Example 3: C is engaged in the construction business and undertakes a project where the builder has no pre-paid client, and the project is speculative. C acquires the land and obtains a construction loan to fund the improvements on the land. The construction loan documents include charges for banking fees that are not pre-paid interest or interest on the loan balance. The banking fees are for a general business service and not considered a construction-related service and therefore not deductible under Section 7-9-52 NMSA 1978.

E. This version of 3.2.210.8 NMAC applies to transactions occurring on or after January 1, 2013.

[12/5/69, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96, 10/31/97; 3.2.210.8 NMAC - Rn, 3 NMAC 2.52.8 & A, 5/31/01; A, XXX]

3.2.210.9 W E L L CONSTRUCTION SERVICES:

A. Receipts from the sale of the following services in connection with well drilling are receipts from the sale of construction services as defined in Section [~~7-9-3~~] 7-9-3.4 NMSA 1978, and may be deducted from gross receipts if all other requirements of Section 7-9-52 NMSA 1978, are met:

(1) dirt work and surfacing;
(2) digging cellars and pits;
(3) drilling ratholes;
(4) drilling water wells;
(5) laying water and fuel lines;
(6) directional drilling services;
(7) casing crew services;
(8) cementing services;
(9) drill stem testing; and
(10) fishing jobs.

B. Receipts from the sale of the following services in connection with well drilling are not receipts from the sale of construction services within the meaning of Section [~~7-9-3~~] 7-9-3.4 NMSA 1978 and may not be deducted from gross receipts:

(1) repairing drilling equipment;
(2) hauling water and mud;
(3) hauling drilling equipment, rigging-up and rigging-down;
(4) field inspecting drill collars and drill stems; and
(5) furnishing compressed air.

C. On or after January 1, 2013, receipts from the sale of the following services in connection with well drilling are receipts from the sale of construction-related services as defined in Section 7-9-52 NMSA 1978 and are deductible under Section 7-9-52 NMSA 1978 if all the requirements of that section are met:

(1) hauling water and mud;
(2) hauling drilling equipment, rigging-up and rigging-down;
(3) field inspecting drill collars and drill stems; and
(4) furnishing compressed air.

[12/5/69, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.9 NMAC - Rn, 3 NMAC 2.52.9 & A, 5/31/01; A, XXX]

3.2.210.10 [~~TRANSPORTATION~~] HAULING SERVICES:

[~~A. HAULING:~~] On or after January 1, 2013, receipts from hauling materials, prefabricated buildings and supplies to and from a building site for a person engaged in the construction business are [~~not~~] construction-related services and are deductible from the hauler's gross receipts pursuant to Section 7-9-52 NMSA 1978 [~~because hauling materials and supplies to and from a construction site is not a construction service pursuant to Subsection A of Section 7-9-3.4 NMSA 1978~~] if all requirements of Section 7-9-52 NMSA 1978 are met.

[~~B. HAULING PREFABRICATED BUILDINGS: A builder of prefabricated buildings may not issue a type 7 nontaxable transaction certificate to a company hired to move completed buildings from the builder's lot to the permanent site. Haulers are not engaged in construction as defined under Section 7-9-3 NMSA 1978. A deduction may be available under Section 7-9-48 NMSA 1978 if all the criteria of that section are met.~~

~~C. HAULING AND SPREADING MATERIALS WITHIN CONSTRUCTION PROJECT: Receipts of a person from hauling and spreading dirt, sand, gravel and rock, treated or untreated, for the purpose of furnishing materials to a construction project when such materials have been obtained from a source which is on or in the proximity of that construction project are receipts from performing a construction service. Such receipts may be deducted from the seller's gross receipts if the buyer delivers a nontaxable transaction certificate to the seller.~~]

[12/5/69, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 3/16/79, 6/18/79, 11/8/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.10 NMAC - Rn, 3 NMAC 2.52.10 & A, 5/31/01; A, 11/30/05; A, XXX]

3.2.210.14 SALVAGING OF A "PRODUCTION UNIT": Receipts of a person engaged in the business of servicing "production units" as defined in the Oil and Gas Emergency School Tax Act, Section 7-31-2 NMSA 1978, from performing services in connection with salvaging of materials from a "production unit" are not receipts from the sale of construction services or from construction-related services within the meaning of Section 7-9-52 NMSA 1978 and may not be deducted from gross receipts.

[3/9/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.14 NMAC - Rn, 3 NMAC 2.52.14 & A, 5/31/01; A, XXX]

3.2.210.15 CLEANING THE CONSTRUCTION SITE:

A. Receipts from cleaning a building upon completion of a construction project; from cleaning masonry upon the completion of a construction project; from making an earth fill for drainage purposes; from providing an earth fill of a granular type required by specifications; and from replacing construction rejected by the architects, the engineers or the owners are receipts from performing construction services. Such receipts may be deducted from gross receipts if the buyer delivers a nontaxable transaction certificate to the seller.

B. Receipts from cleaning the building at any time other than during or immediately after completion of the construction project or cleaning masonry in a standing building in order to restore its appearance [~~from performing concrete and soil tests and from charges for maintaining a watchman on a construction project during the construction period are not receipts from performing construction services as that term is used in Section 7-9-52 NMSA 1978 and~~

~~may not be deducted from gross receipts~~] are not deductible under Section 7-9-52 NMSA 1978.

[3/9/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.15 NMAC - Rn, 3 NMAC 2.52.15 & A, 5/31/01; A, XXX]

3.2.210.16 DAMAGE TO A CONSTRUCTION PROJECT BY SUBCONTRACTOR:

A. Charges by a contractor to a subcontractor for damages to a construction site caused by the subcontractor are not gross receipts to the contractor, but constitute a reduction in the amount of consideration paid to the subcontractor for the service performed by the subcontractor.

B. Example: A, a prime contractor, contracts with C, an independent contractor, to repair a part of a construction project damaged by B, a subcontractor on the project. B is responsible to A for the cost of such repair. A also contracts with D, a person engaged in the business of hauling trash, to remove trash and debris left by B after completion of B's portion of the project. B is obligated by the terms of the contract to remove the trash and debris. A charges B for the cost of repair paid to C and for the cost of hauling paid to D, either by deducting such cost from the amount A will pay B upon completion of B's work or by billing B directly for them.

(1) A's charges to B for the cost of repair is a reduction in the cost of A's subcontract with B. A, therefore, derives no receipts from the charge to B, regardless of whether A subtracts the cost of work done by C from the amount A pays B or whether B pays A the cost of the work performed by C.

(2) A may deliver a nontaxable transaction certificate (nttc) to C, the independent contractor, if the service performed by C is a construction service within the meaning of Section 7-9-52 NMSA 1978.

(3) On or after January 1, 2013, A may [~~not~~] deliver an nttc to D for hauling trash, since hauling is [~~not a construction service~~] a construction-related service within the meaning of Section 7-9-52 NMSA 1978 if all the requirements of that section are met.

[3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.16 NMAC - Rn, 3 NMAC 2.52.16 & A, 5/31/01; A, XXX]

3.2.210.18 LABORATORY WORK AND ENVIRONMENTAL TESTING:

A. Prior to January 1, 2013, receipts of a person engaged in the business of performing laboratory work, such as the design or testing of dirt or concrete work, from the sale of these services to a person engaged in the construction business are not construction services within the meaning of Section 7-9-52 NMSA 1978 and may not be deducted from the seller's gross receipts pursuant to Section 7-9-52 NMSA 1978.

B. Receipts for laboratory work or environmental testing performed on or after January 1, 2013, are receipts from performing construction-related services as defined in Section 7-9-52 NMSA 1978 and are deductible if the requirements of Section 7-9-52 NMSA 1978 are met.

C. Example: X is engaged in the construction business. In order to comply with the requirements of the federal environmental protection agency, X must obtain the services of Y, a certified lead paint consultant. Y will test for the existence of lead paint in any building being demolished or remodeled by X, prepare a federally required report, suggesting additional best management practices, and send samples to a testing lab. Services provided by Y after January 1, 2013, are construction-related services and are deductible under Section 7-9-52 NMSA 1978 as long as all the requirements in the statute are met.

[3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.18 NMAC - Rn, 3 NMAC 2.52.18 & A, 5/31/01; A, XXX]

3.2.210.19 [~~BLUEPRINTS - PHOTOSTATS~~: ~~Receipts from the sale of blueprints or photostats to a person engaged in the construction business are subject to the gross receipts tax. These receipts may not be deducted pursuant to Section 7-9-52 NMSA 1978 because they are not construction services.~~] **CONSTRUCTION-RELATED SERVICES AND ASSOCIATED PRODUCTS:**

A. Receipts from the sale of design services and special inspections that are required to verify specifications in design criteria to a person engaged in the construction business, are construction-related services and deductible under Section 7-9-52 NMSA 1978.

B. Receipts from the sale of building plans, professional stamps, or similar products to a person engaged in the construction business are construction-related services as defined in Section 7-9-52. Receipts from such sales that are contracted for or billed to a construction project may be deducted from the seller's gross receipts pursuant to Section 7-9-52 NMSA 1978 if the buyer is engaged in the construction business and delivers a nontaxable transaction certificate to the seller.

C. Example 1: C is engaged in the construction business. In order to begin the construction project C obtains the services of A, a design/architectural firm, to draw the plans necessary to obtain the building permit. Under Section 7-9-52 NMSA 1978, the plan preparations are a construction-related service. As long as the construction project is subject to gross receipts tax upon its completion, or located on tribal land, C may execute an nttc to A and A's receipts will be deductible under Section 7-9-52 NMSA 1978 as construction-related services.

D. Example 2: X is engaged in the construction business and contracts with Y, who is also engaged in the construction business, for the design and construction of the mechanical ducting system on X's construction project. Building code requires certain portions of the mechanical system to be designed by a mechanical engineer. Y, enters into a contract for the services of E, an engineering firm, to perform the calculations, design a portion of the system, and place an engineer's "seal" on E's part of the mechanical ducting design. E is able to accept an nttc from Y as E's service is a construction-related service as defined in Section 7-9-52 NMSA 1978. X may also execute an nttc under Section 7-9-52 NMSA 1978 to Y so long as the X's completed project is subject to gross receipts tax.

E. This version of 3.2.210.19 NMAC applies to transactions occurring on or after January 1, 2013.

[3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.19 NMAC - Rn, 3 NMAC 2.52.19 & A, 5/31/01; A, 11/30/05; A, XXX]

3.2.210.20 COMPENSATING TAX ON CONSTRUCTION SERVICES: When a person engaged in the construction business leases out or otherwise uses a construction project for which construction services or construction-related services were purchased using a nontaxable transaction certificate (nttc), the compensating tax is due if the project is occupied or leased prior to sale. The value of the construction services or construction-related services to be reported is the actual cost of the construction services purchased using nttcs, and the tax is due at the time of occupancy.

[7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.20 NMAC - Rn, 3 NMAC 2.52.20, 5/31/01; A, XXX]

3.2.210.21 MUD ENGINEERING SERVICES: Gross receipts from providing a mud engineering service at the well site to supervise the mixing of various agents and to make recommendations as to the type of fluids needed for the particular formations encountered in drilling wells are [~~not~~] receipts from providing construction-related services as defined in Section 7-9-52 NMSA 1978 and are deductible pursuant to Section 7-9-52 NMSA 1978. [~~Mud engineering service is a professional service, not a construction service.~~] Receipts from mud engineering services performed after January 1, 2013,

may be deductible pursuant to Section 7-9-52 NMSA 1978 if a buyer engaged in the construction business delivers a nontaxable transaction certificate to the seller.

[3/16/79, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.21 NMAC - Rn, 3 NMAC 2.52.21 & A, 5/31/01; A, XXX]

3.2.210.22 LEASE OF CONSTRUCTION EQUIPMENT:

A. This version of 3.2.210.22 NMAC applies to transactions prior to January 1, 2013. Receipts from the lease of construction equipment on or after January 1, 2013, may be deductible under Section 7-9-52.1 NMSA 1978, if all requirements set out in Section 7-9-52.1 NMSA 1978 and 3.2.249.8 and 9 NMAC are met.

[~~A.~~] B. Receipts from leasing construction equipment, with or without operators, to a person engaged in the construction business may not be deducted from the lessor's gross receipts pursuant to Section 7-9-52 NMSA 1978. Leasing of construction equipment is not a construction service as defined in Subsection A of Section 7-9-3.4 NMSA 1978.

[~~B.~~] C. In contrast, when a person who is regularly engaged in the selling of construction services, such as a subcontractor, uses the subcontractor's own construction equipment to perform construction services for a person engaged in the construction business, the subcontractor may deduct the receipts for the services and equipment under Section 7-9-52 NMSA 1978 if:

(1) the subcontractor is an independent contractor and not an employee of the person engaged in the construction business; and

(2) the subcontractor exercises control over the use of the property in performing the services; the controlling factor is whether the equipment owner has control over the performance of the construction service which involves using the equipment or is simply operating the equipment at the direction of some other person engaged in the construction business.

[~~C.~~] D. Example 1: A is regularly engaged in the lease and rental of construction equipment. A enters into an agreement to lease a crane with an operator to a contractor engaged in the construction business to be used on a construction project. The contractor will direct all of the activity of the crane and operator on the construction site. A's receipts from the lease of the crane with an operator are not receipts from performing construction services. A cannot deduct such receipts.

[~~D.~~] E. Example 2: X is a heating and air conditioning subcontractor on a construction project. X owns a crane which X regularly uses to lift equipment onto the roof of buildings on which X works. X's receipts for construction services includes payment for using the crane. X may deduct those receipts under Section 7-9-52 NMSA 1978. If, however, X agrees to lease the crane with an operator to the prime contractor for work unrelated to the subcontract, which work is performed at the direction of the prime contractor, X would not be able to deduct the receipts for the leasing of the crane.

[11/8/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.22 NMAC - Rn, 3 NMAC 2.52.22 & A, 5/31/01; A, 11/30/05; A, XXX]

3.2.209.22 [~~INGREDIENT AND COMPONENT PARTS OF A CONSTRUCTION PROJECT:~~ ~~In determining whether tangible personal property will become an ingredient or component part of a construction project, the department will use the following criteria, but not exclusively:~~

~~A. Did the tangible personal property become "fixtures" as defined under Subsection I of Section 3.2.1.11 NMAC?~~

~~B. Was the person performing the work using the tangible personal property required to be licensed under the Construction Industries Licensing Act, Sections 60-13-1 to 60-13-59 NMSA 1978?~~

~~C. Did the work for which the tangible personal property was used require a permit from one or more of the trade boards established by the Construction Industries Licensing Act or from a municipal building or mechanical department?~~] [RESERVED]

[6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.209.22 NMAC - Rn, 3 NMAC 2.51.22 & A, 5/31/01; Repealed, XXX]

3.2.210.7 DEFINITIONS: [~~HAULING AND SPREADING DEFINED:~~ ~~For purposes of Subsection C of Section 3.2.210.10 NMAC, hauling and spreading means the transporting of material from a location on or in proximity to a construction site and applying the material to the point of usage required as a step in completing the construction project.~~] [RESERVED]

[11/15/96; 3.2.210.7 NMAC - Rn, 3 NMAC 2.52.7, 5/31/01; A, 11/30/05; Repealed, XXX]

3.2.210.12 [~~"SWEAT LABOR CONTRACT":~~ ~~Receipts of a person who performs construction services pursuant to a "sweat labor contract" include the value of the consideration received from the sale of construction services pursuant to the "sweat labor contract". However, such a person may deduct the receipts from the sale of these construction services to a person engaged in the construction business if the person engaged in the construction business delivers a nontaxable transaction certificate pursuant to Section 7-9-52 NMSA 1978.~~] [RESERVED]

[3/9/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.12 NMAC - Rn, 3 NMAC 2.52.12 & A, 5/31/01; Repealed, XXX]

NEW MEXICO WATER QUALITY CONTROL COMMISSION

NEW MEXICO WATER QUALITY CONTROL COMMISSION NOTICE OF PUBLIC HEARING TO CONSIDER PETITION TO AMEND SURFACE WATER QUALITY STANDARDS FOR NICHOLS AND MCCLURE RESERVOIRS, THE SANTA FE RIVER AND GALISTEO WATERSHED 20.6.4 NMAC, WQCC 12-07 (R)

The New Mexico Water Quality Control Commission (WQCC) will hold a public hearing on December 11, 2012 and continuing on subsequent days as necessary in Room 307 of the State Capitol Building, Santa Fe, NM 87501 to consider proposed amendments to the Standards for Interstate and Intrastate Surface Waters, 20.6.4 NMAC. The WQCC will begin its regular monthly meeting at 9:00 am, and the public hearing will begin at the conclusion of its regular business.

The proposed amendments to 20.6.4 NMAC, submitted by the New Mexico Environment Department (NMED), propose to change the classification of Nichols and McClure Reservoirs, classify the Santa Fe River through the city of Santa Fe, modify criteria that apply to the Santa Fe River below the wastewater treatment facility, and change the classification of a portion of the Galisteo Watershed.

NMED's Petition is available at http://www.nmenv.state.nm.us/swqb/. The Petition may also be obtained electronically or reviewed in person by contacting:
Pam Castaneda
WQCC Administrator
1190 S. St. Francis Drive
PO Box 5469
Santa Fe, NM 87502
Tel (505) 827-2425, Fax (505) 827-2836, E-mail pam.castaneda@state.nm.us

The hearing will be conducted in accordance with Section 74-6-6 of the Water Quality Act, the Guidelines for WQCC Regulation Hearings, and the Procedural Order and Scheduling Order issued by the WQCC

Hearing Officer. These documents are available at: http://www.nmenv.state.nm.us/WQCC/ or by contacting the WQCC Administrator.

Technical Testimony:

In order to present technical testimony at the hearing, a person must file a notice of intent to present technical testimony in WQCC No. 12-07 (R) with the WQCC Administrator no later than November 19, 2012 at 5:00 pm. The notice shall:

1. Identify the person for whom the witness(es) will testify;
2. Identify each technical witness the person intends to present and state the qualifications of that witness including a description of their educational and work background;
3. Attach the full direct testimony of each technical witness;
4. State the anticipated duration of the direct testimony of each technical witness;
5. Include the text of any recommended modifications to the proposed regulatory change and a statement of basis;
6. Identify and attach all exhibits to be offered by the person at the hearing in their direct case; and
7. Identify whether the person supports or opposes the nomination to be considered by the WQCC and the basis for the position.

The Hearing Officer shall enforce the above requirements through the exclusion of technical testimony, exhibits or recommended modifications, as appropriate.

Participation by the General Public:

Any member of the general public may present non-technical testimony and exhibits at the hearing. No prior notification is required. Persons desiring to present non-technical testimony may be heard at the end of each technical case, and at other times as the hearing officer allows. A member of the general public may submit a written non-technical statement for the record to the WQCC Administrator in lieu of oral testimony at any time prior to the hearing or at the hearing at any time prior to the close of the hearing.

Post-hearing Procedures

At the conclusion of the hearing, the WQCC may make a final decision or may provide information regarding post-hearing submittals and a timeframe for its final decision.

Assistance

If any person requires assistance, an interpreter or auxiliary aid to participate in this process, please contact Connie Joseph at least ten days prior to the hearing date at NMED, Personnel Service Bureau, Room N-4071, 1190 S. St. Francis Drive, PO Box 5469, Santa Fe, NM 87502, (505) 827-9769. TDY users may access Ms. Joseph's number through the New Mexico Relay Network at 1-800-659-8331.

End of Notices and Proposed Rules Section

Adopted Rules

NEW MEXICO EDUCATIONAL RETIREMENT BOARD

This is an amendment to 2.82.3 NMAC, Sections 2, 8, 10 and 11, effective 10-15-2012.

2.82.3.2 SCOPE: This rule defines earnings on which member contributions shall be made, refund of contributions, purchase of contributory employment and non-reported service, and the payment of interest on refunds.
[2.82.3.2 NMAC - Rp, 2.82.3.2 NMAC, 7-1-2012; A, 10-15-2012]

2.82.3.8 [~~E A R N I N G S~~] SALARY COVERED; SALARY EXCLUDED:

A. Except as otherwise set forth herein and subject to the limitations set forth in Section 22-11-21.2, a member's annual salary for the purpose of contributions to the fund and computation of the member's benefit shall consist of total compensation or wages paid to the member for services rendered during each of the four calendar quarters of a fiscal year, beginning July 1 and ending June 30, excluding any salary earned while employed under the return to work program of the Educational Retirement Act.

(1) Salary includes payments made directly to the member or to a third party on behalf of or for the benefit of the member. Salary includes, without limitation:

(a) base salary, compensation, or wages;

(b) salary, compensation or wages for additional services rendered; examples include: teaching courses in addition to or above a full teaching load during the September to May academic year; teaching courses or performing research during summer (e.g., June through August) where such courses or research are not included in the duties on which the member's salary is based; and, performing work in addition to that specified in the employee's job description; performing administrative duties, such as serving as a department head, head of a faculty or staff group, or for providing other additional services;

(c) salary, compensation or wages based on professional certifications or qualifications, or skills such as being bilingual or multilingual;

(d) overtime, shift differential, and 'on-call' or call back pay.

(2) Retirement contributions shall be made by a local administrative unit and a member on base salary earnings before the salary is reduced due to the local administrative unit and member entering into a voluntary "cafeteria" plan.

(3) The salary or compensation paid to a member under a school bus owner-driver contract shall be covered for contributions and benefit calculation purposes. Contributions for compensation paid under a school bus owner-driver contract shall be based upon and limited to the compensation amount paid to a person who drives a single school bus owned by that person over a regularly established route under a regular contract in that person's name with a local administrative unit.

(4) Tips or other remuneration paid to a member by a third party are considered salary to the extent that a local administrative unit reports such amounts as the member's income for tax purposes.

B. The following items shall not be considered annual salary for the purposes of contributions to the fund and computation of the member's annual benefit:

(1) Bonuses, awards and prizes, pay supplements or salary supplements or other "one-time" payments which do not increase an employee's annual base pay or which are made in lieu of an increase in base pay, and similar additional payments, as well as allowances or reimbursements for travel, housing, food, equipment or similar items.

(2) Lump-sum payments to the member for accrued sick leave made at any time, and lump-sum payments of accrued annual leave (also referred to as "vacation leave") made after July 1, 2010. Lump-sum payments for accrued annual leave made on or before July 1, 2010 shall be includable as annual salary only to the extent that it does not include payment for more than thirty (30) days of such leave.

(3) Payments made by a local administrative unit to a member where services are not rendered. By way of example, and with limitation to such examples: (a) payments by an employer to "buy-out" the remaining term of a member's employment contract or in connection with an early retirement program are not payments for services rendered, irrespective of whether payment is made in a lump-sum or distributed over a period of time, and (b) payments as a result of a legal settlement, whether related to the member's employment or otherwise, are not payments for services rendered, unless such payments are specifically made for salary that was not previously paid.

(4) Stipends, salary, or other compensation paid to student teachers.

(5) Stipends or one-time payments for attending training sessions where such payments are not reimbursements for travel expenses.

(6) Allowances or reimbursements for, or expenses related to, travel, housing, food, equipment, cars, or similar items.

(7) After July 1, 2012, additional pay or a pay differential that is based solely on a member performing duties at (a) a location that is different than the location at which the member regularly performs his or her job duties or (b) that is based on the member performing duties outside of the United States and its insular areas, territories, and possessions (e.g., a location differential or hazard or hazardous duty pay).
[2.82.3.8 NMAC - Rp, 2.82.3.8 NMAC, 7-1-2012; A, 10-15-2012]

2.82.3.10 [~~PURCHASE OF CONTRIBUTORY EMPLOYEMENT~~] REFUNDS OF CONTRIBUTIONS IN THE EVENT OF DEATH OF MEMBER OR BENEFICIARY:

A. In the event of the death of an active member who is not vested, member contributions together with interest calculated at the refund rate shall be refunded to the member's beneficiary or to the member's estate upon completion of the proper refund forms as provided for herein.

B. In the event of the death of a vested member who did not select Option B benefits prior to the effective date of retirement, the deceased member's beneficiary shall be have the option of electing to receive a refund of the member's contributions or receiving benefits in the form of Option B as provided in Section 22-11-29 NMSA 1978. Refunds, together with interest calculated at the refund rate and reduced by the sum of any disability benefits which that member might have previously received, shall be paid to the member's surviving beneficiary or estate. If a beneficiary defers payment after the member dies as described in Section 22-11-29 NMSA 1978 and requests a lump sum payment in lieu of benefit under Option B, interest shall be calculated at the refund rate though the end of the calendar quarter prior to the date on which the completed refund request is received by the ERB. Under the provisions of Options B and C, if both the member and the designated beneficiary die before the total of the retirement benefits received by the member and the beneficiary equal the total contributions made by the member, the difference, less any disability benefits previously paid to the member, shall be paid to the member's or the beneficiary's estate.

C. In order to obtain a refund of contributions after the death of a member, the member's beneficiary must notify the director of the member's death and furnish a copy of the death certificate or other proof of death acceptable to the director, whereupon the director shall furnish

the beneficiary the proper forms to request a refund.

D. If the amount of a deceased member's contribution does not exceed the sum of $1,000.00 and no written claim is made to the board for it within one year from the date of the member's death, by the member's surviving beneficiary or estate, payment thereof may be made to the named beneficiary or, if none is named, to the person that the board determines to be entitled to the contribution under the laws of New Mexico.

[2.82.3.10 NMAC - Rp, 2.82.3.10 NMAC, 7-1-2012; A, 10-15-2012]

2.82.3.11 [~~INTEREST CREDITS AND PAYMENTS ON MEMBERCONTRIBUTIONS~~]RETURN OF REFUNDED CONTRIBUTIONS AND RETIREMENT ELIGIBILITY:

A. Member contributions which have been withdrawn from the fund by a member who has terminated employment may be returned to the fund, together with interest at the rate set by the board, without the member being required to return to employment if the termination was under one of the following circumstances:

(1) the member terminated employment for reasons other than by retirement, disability or death;

(2) the member exempted himself or herself from the Educational Retirement Act; or

(3) the member has not been reemployed following a period of disability during which the member received disability benefits.

B. Contributions restored to the fund after having been withdrawn by a member that were originally made prior to July 1, 1971 shall not be considered as having been paid to the fund after July 1, 1971 for the purpose of earning interest and no interest shall be paid on such restored contributions.

C. Effective July 1, 2011, a member who was a member at any time prior to July 1, 2010 and who, on or before June 30, 2010, had all of his or her member contributions refunded pursuant to Section 22-11-15 NMSA 1978, and who, on or after July 1, 2010, returns to employment or returns the withdrawn contributions to the fund together with interest at the rate set by the board, is eligible to retire as if initially becoming a member on or after July 1, 2010.

[2.82.3.11 NMAC - Rp, 2.82.3.11 NMAC, 7-1-2012, A, 10-15-2012]

NEW MEXICO DEPARTMENT OF HEALTH

TITLE 7 HEALTH
CHAPTER 25 STATE HEALTH INSTITUTIONS
PART 2 DRUG AND ALCOHOL TESTING OF EMPLOYEES

7.25.2.1 ISSUING AGENCY: New Mexico Department of Health.
[7.25.2.1 NMAC - N, 10/15/2012]

7.25.2.2 SCOPE: This rule applies to all employees providing direct health care services in state health facilities as defined in NMSA 1978, Section 9-7-18.
[7.25.2.2 NMAC - N, 10/15/2012]

7.25.2.3 STATUTORY AUTHORITY: Section 9-7-18 of the Department of Health Act, NMSA 1978, Sections 9-7-1 through 9-7-18.
[7.25.2.3 NMAC - N, 10/15/2012]

7.25.2.4 DURATION: Permanent.
[7.25.2.4 NMAC - N, 10/15/2012]

7.25.2.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.
[7.25.2.5 NMAC - N, 10/15/2012]

7.25.2.6 OBJECTIVE: To protect the health and welfare of those served in state health care facilities operated by the department of health by ensuring that employees providing direct health care are not impaired by any illegal or prescription drug, or alcohol, while providing services.
[7.25.2.6 NMAC - N, 10/15/2012]

7.25.2.7 DEFINITIONS:

A. "Direct care" means health care providers authorized or permitted to offer health care services directly to a patient without another employee's assistance or presence.

B. "Department" means the department of health.

C. "For cause" means upon reasonable suspicion of impairment as set forth in 1.7.8 NMAC.

D. "Health care provider" means any health care staff member who is licensed, certified or otherwise authorized or permitted by law to provide direct, unsupervised health care to a patient.

E. "Illegal or prescription drug" means a substance listed in any of Schedules I through V of the Controlled Substances Act.

F. "State health care facility" means a hospital, an entity providing services for the developmentally disabled, a shelter care home, a free-standing hospice or a home health agency operated by the department.

[7.25.2.7 NMAC - N, 10/15/2012]

7.25.2.8 TESTING REQUIREMENTS:

A. All direct care health care providers shall be deemed employed in safety-sensitive positions to be tested for drug or alcohol abuse prior to employment, and subject to both random and for cause drug and alcohol testing thereafter pursuant to the rules promulgated by the state personnel board set forth at 1.7.8 NMAC, which rules are hereby incorporated by reference.

B. Any safety-sensitive employee may be tested without prior notice for drug or alcohol abuse upon reasonable suspicion of impairment.

(1) All reports of suspected drug or alcohol impairment while working shall be investigated by the allegedly impaired employee's supervisor, and if believed credible based upon direct observation of the factors listed in Subsection C of 1.7.8.11 NMAC, the employee shall be tested immediately upon approval of the next level supervisor as set forth in that section.

(2) The immediate supervisor must provide a succinct memorandum of the factors which led him or her to conclude the allegation was credible to the department's substance abuse coordinator or designee within 24 hours of testing.

C. Drug or alcohol test results shall be reported in writing only to the department's substance abuse coordinator or designee. Positive test results will be provided in writing to the prospective new hire or employee along with a copy of this rule including 1.7.8 NMAC.

[7.25.2.8 NMAC - N, 10/15/2012]

HISTORY OF 7.25.2 NMAC: [RESERVED]

NEW MEXICO DEPARTMENT OF HEALTH

DIVISION OF HEALTH IMPROVEMENT

The New Mexico Department of Health repeals its rule entitled "Hearing Requirements for Certified Nurse Aides", 16 NMAC 12.20 (filed 10/18/96) and replaces it with 16.12.20 NMAC entitled "Hearing Requirements for Certified Nurse Aides", effective 10/15/12.

NEW MEXICO DEPARTMENT OF HEALTH
DIVISION OF HEALTH IMPROVEMENT

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 12 NURSES AND HEALTH CARE RELATED PROVIDERS
PART 20 HEARING REQUIREMENTS FOR CERTIFIED NURSE AIDES

16.12.20.1 ISSUING AGENCY: New Mexico Department of Health; Public Health Division; Health Facility Licensing and Certification Bureau.
[16.12.20.1 NMAC - Rp, 16 NMAC 12.20.1, 10/15/12]

16.12.20.2 SCOPE: These regulations apply to nurse aides on the nurse aide registry who may perform nurse aide duties at medicare or medicaid facilities.
[16.12.20.2 NMAC - Rp, 16 NMAC 12.20.2, 10/15/12]

16.12.20.3 STATUTORY AUTHORITY: The regulations set forth herein have been promulgated by the secretary of the New Mexico department of health by authority of Sections 9-7-6(E), 24-1-3(0), and 24-2-5(B) NMSA 1978.
[16.12.20.3 NMAC - Rp, 16 NMAC 12.20.3, 10/15/12]

16.12.20.4 DURATION: Permanent.
[16.12.20.4 NMAC - Rp, 16 NMAC 12.20.4, 10/15/12]

16.12.20.5 EFFECTIVE DATE: October 15, 2012, unless a different date is cited at the end of a section.
[16.12.20.5 NMAC - Rp, 16 NMAC 12.20.5, 10/15/12]

16.12.20.6 OBJECTIVE: The purpose of these regulations is to:

A. provide for notification to the nurse aide of allegations of abuse, neglect, or exploitation;

B. provide the opportunity for a hearing to the nurse aide against whom an allegation of abuse, neglect, or exploitation has been made;

C. provide for notification to the nurse aide and the nurse aide registry if the allegations are substantiated and upheld following any appeal requested pursuant to these regulations.
[16.12.20.6 NMAC - Rp, 16 NMAC 12.20.6, 10/15/12]

16.12.20.7 DEFINITIONS: For purposes of these regulations the following shall apply.

A. "Abuse" means any act or failure to act performed intentionally, knowingly or recklessly that causes or is likely to cause harm to a resident, including:

(1) physical contact that harms or is likely to harm a resident of a health facility;

(2) inappropriate use of a physical restraint, isolation, or medication that harms or is likely to harm a resident;

(3) inappropriate use of a physical or chemical restraint, medication, or isolation as punishment or in conflict with a physician's order;

(4) medically inappropriate conduct that causes or is likely to cause physical harm to a resident;

(5) medically inappropriate conduct that causes or is likely to cause great psychological harm to a resident;

(6) an unlawful act, a threat or menacing conduct directed toward a resident that results and might reasonably be expected to result in fear or emotional or mental distress to a resident.

B. "Exploitation" of a resident consists of the act or process, performed intentionally, knowingly, or recklessly, of using a resident's property for another person's profit, advantage or benefit without legal entitlement to do so.

C. "Facility" means a skilled nursing facility or nursing facility, or a distinct part of a skilled nursing facility or nursing facility.

D. "Great psychological harm" means psychological harm that causes mental or emotional incapacitation for a prolonged period of time or that causes extreme behavioral change or severe physical symptoms that require psychological or psychiatric care.

E. "Licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

F. "Neglect" means subject to the resident's right to refuse treatment and subject to the caregiver's right to exercise sound medical discretion, the grossly negligent:

(1) failure to provide any treatment, service, care, medication or item that is necessary to maintain the health or safety of a resident;

(2) failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a resident;

(3) failure to carry out a duty to supervise properly or control the provision of any treatment, care, good, service or medication necessary to maintain the health or safety of a resident.

G. "Nurse aide" means any individual who provides nursing or nursing related services to residents in a facility and who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay.

H. "Registry" means a listing by the state survey agency of all individuals who have satisfactorily completed a nurse aide training or competency evaluation program approved by the department of health and state survey agency, or who have qualified by reciprocity.

I. "Resident" means any person who resides in a health care facility or who receives treatment from a certified health care provider.

J. "Survey agency" means the health facility licensing and certification bureau of the New Mexico department of health.
[16.12.20.7 NMAC - Rp, 16 NMAC 12.20.7, 10/15/12]

16.12.20.8 INVESTIGATION: Following review by the survey agency, all allegations for which there is reason to believe, either through oral or written evidence, that the resident has been abused, neglected or exploited will be investigated.
[16.12.20.8 NMAC - Rp, 16 NMAC 12.20.8, 10/15/12]

16.12.20.9 SOURCE OF COMPLAINTS: All complaints received by the survey agency for which there is reason to believe that the resident has been abused, neglected or exploited will be investigated regardless of their source.
[16.12.20.9 NMAC - Rp, 16 NMAC 12.20.9, 10/15/12]

16.12.20.10 NOTIFICATION: If the survey agency determines, based on oral or written evidence, that resident abuse, neglect or exploitation occurred, it shall notify by mail the nurse aide implicated in the investigation and the administrator of the facility that employs the nurse aide of the:

A. nature of the allegation(s);

B. date of the occurrence;

C. right to a hearing;

D. survey agency's intent to report the substantiated findings, once the nurse aide has had the opportunity for a hearing, to the nurse aide registry and other appropriate licensure authorities;

E. fact that the nurse aide's failure to request a hearing in writing within 30 days from the date of the notice will result in the survey agency reporting the substantiated findings to the administrator of the facility that employs the nurse aide to the nurse aide registry.
[16.12.20.10 NMAC - Rp, 16 NMAC

12.20.10, 10/15/12]

16.12.20.11 REQUEST FOR HEARING: A nurse aide determined by the survey agency to have committed abuse, neglect, or exploitation may request an administrative hearing. The request for a hearing shall be in writing and mailed or delivered to the New Mexico department of health as directed in the notification sent pursuant to 16.12.20.10 NMAC.
[16.12.20.11 NMAC - Rp, 16 NMAC 12.20.11, 10/15/12]

16.12.20.12 IMPARTIAL HEARING OFFICER: Upon receipt of a timely request for a hearing, the secretary of the department of health or his or her designee shall appoint an impartial hearing officer to conduct the hearing and issue a report and recommended decision. The hearing officer need not be an attorney. The hearing officer must not have been involved in any way in the action which is challenged in the hearing.
[16.12.20.12 NMAC - Rp, 16 NMAC 12.20.12, 10/15/12]

16.12.20.13 PARTIES: The parties to a hearing conducted under these regulations shall be the survey agency and the nurse aide.
[16.12.20.13 NMAC - Rp, 16 NMAC 12.20.13, 10/15/12]

16.12.20.14 PRE-HEARING DISCOVERY:

A. Upon written request, the nurse aide who has requested a hearing shall be entitled to review and copy documents in the survey agency's file that are relevant to the challenged action. Documents protected by confidentiality or privilege, however, shall not be inspected or copied.

B. The parties shall disclose to each other verbally, or in writing, and to the hearing officer, the names of witnesses to be called and the general subject matter of their testimony no later than two days prior to the hearing. No formal depositions shall be allowed, although if the witnesses do not object, they may be informally interviewed prior to their testimony.
[16.12.20.14 NMAC - Rp, 16 NMAC 12.20.14, 10/15/12]

16.12.20.15 SCHEDULING THE HEARING:

A. The hearing shall take place within 30 days after the survey agency's receipt of the request for a hearing.

B. The survey agency or, if so delegated, the hearing officer shall schedule the hearing at a place and time reasonably convenient for the nurse aide and shall provide reasonable notice to the parties and to the administrator of the facility that employs the nurse aide of the place and time of the hearing.
[16.12.20.15 NMAC - Rp, 16 NMAC 12.20.15, 10/15/12]

16.12.20.16 CONDUCT OF HEARING:

A. The hearing officer shall conduct the hearing in public except when a closed hearing is requested in order to protect confidential information.

B. The survey agency has the burden of proving, by a preponderance of the evidence, the existence of the conduct relied upon to take the challenged action.

C. Testimony shall be under oath and witnesses are subject to cross examination.

D. The rules of evidence do not apply, however, evidence shall be admitted if it is the type that a reasonable person would rely on in the conduct of his/her affairs.

E. If a nurse aide demonstrates that resident neglect was caused by factors beyond his or her control, such showing shall constitute a defense to the charge of neglect.

F. A record made by audio recording device shall be maintained with the hearing officer's file.
[16.12.20.16 NMAC - Rp, 16 NMAC 12.20.16, 10/15/12]

16.12.20.17 REPORT AND RECOMMENDATIONS OF HEARING OFFICER: The hearing officer shall render and mail a written report and recommended decision within five working days of the conclusion of the hearing to the secretary of the department of health or his or her designee. The report shall state the basis of such decision and recommend final action to the secretary or the designee. The decision need not contain formal findings of fact or conclusions of law.
[16.12.20.17 NMAC - Rp, 16 NMAC 12.20.17, 10/15/12]

16.12.20.18 FINAL DECISION: The secretary, or his or her designee, shall render a final determination within 10 days of the submission of the hearing officer's report. Parties may be notified personally, by telephone or by mail of the final order. A copy of the final decision shall be mailed to each party or attorney of record.
[16.12.20.18 NMAC - Rp, 16 NMAC 12.20.18, 10/15/12]

16.12.20.19 REPORT OF FINDINGS: If the secretary, or his or her designee, finds that the nurse aide has abused, neglected, or exploited a resident the survey agency shall report these findings to:

A. the nurse aide;

B. the administrator of the facility that employs the nurse aide; and

C. the nurse aide registry.
[16.12.20.19 NMAC - Rp, 16 NMAC 12.20.19, 10/15/12]

16.12.20.20 REPORT OF FINDINGS TO THE NURSE AIDE REGISTRY: Within 10 working days of the secretary's, or his or her designee's, findings, the survey agency shall report the following information to the nurse aide registry:

A. the finding made by the secretary, or his or her designee, as a result of the hearing;

B. any statement by the nurse aide disputing the finding;

C. that the nurse aide waived the right to a hearing, if applicable;

D. any failure by the nurse aide to respond to the allegation.
[16.12.20.20 NMAC - Rp, 16 NMAC 12.20.20, 10/15/12]

16.12.20.21 REQUIRED CONTENT OF REGISTRY RECORDS: The survey agency shall retain in accordance with state of New Mexico recordkeeping requirements:

A. records of occurrence;

B. investigative reports;

C. hearing findings;

D. waiver of hearing rights.
[16.12.20.21 NMAC - Rp, 16 NMAC 12.20.21, 10/15/12]

16.12.20.22 APPEAL OF FINAL ACTION: A party may appeal the secretary's, or his or her designee's, final action to the first judicial district court in Santa Fe pursuant to Rule 1-075, NMRA within 30 days from the date of the final action. An appeal does not stay the final action.
[16.12.20.22 NMAC - Rp, 16 NMAC 12.20.22, 10/15/12]

16.12.20.23 RIGHT TO PETITION THE REMOVAL OF NAME FROM THE NURSE AIDE REGISTRY IN CASES OF NEGLECT: A nurse aide may petition the department of health for the removal of his or her name from the nurse aide registry in cases where there was a finding of neglect. Petitions for removal will not be accepted when the finding was for abuse, physical or verbal. Such petitions shall be made in writing and mailed or hand delivered to the Department of Health, Division of Health Improvement, HFL&C Bureau Chief, 2040 South Pacheco St., Santa Fe, New Mexico 87505. The following procedures apply to nurse aides who petition for the removal of his or her name from the nurse aide registry.

A. The nurse aide may petition the department after one year from

the date that he or she was placed on the nurse aide registry. In his or her petition the nurse aide must show that through their employment and personal history that their performance as a nurse aide does not reflect a pattern of abusive behavior or neglect; and that neglect involved in the original finding was a singular occurrence.

B. Within 30 days of receipt of a petition the department shall set the date for a hearing. Failure to petition within 30 days from the conclusion of the one year period shall result in forfeiture of the person's right to a hearing. Such a request shall be made in writing and mailed, or hand delivered, and shall be accompanied by a payment of forty dollars ($40.00) or a sworn statement of indigence on a form provided by the department. The hearing shall be held in Santa Fe, New Mexico at the department of health.

C. In the event that the department denies the petition, the department will notify the nurse aide within 30 days of the reasons for denying the petition and the nurse aide will continue to be placed on the nurse aide registry.

D. If the secretary of the department of health, or his or her designee, determines that the nurse aide does not show a pattern of abusive behavior or neglect, and the neglect involved was a singular occurrence, the nurse aide shall be placed in probationary status on the nurse aide registry. The period of probation will be determined by the secretary, or his or her designee, and shall not exceed one year. During the probationary period the nurse aide must complete necessary training involving resident's rights, or other training approved by the health facility licensing and certification bureau. Upon successful completion of the probationary period the nurse aide's certification will be reinstated, and he or she will be removed from the nurse aide registry.

[16.12.20.23 NMAC - Rp, 16 NMAC 12.20.23, 10/15/12]

HISTORY OF 16.12.20 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

DOH 93-7 (PHD), Regulations Governing Hearing Procedures for Nurse Aides in New Mexico, filed 9/1/93.

History of Repealed Material:

16 NMAC 12.20, Hearing Requirements For Certified Nurse Aides, filed 10/18/96 - Repealed, effective 10/15/12.

Other History:

16 NMAC 12.20, Hearing Requirements For Certified Nurse Aides, filed 10/18/96 was renumbered, reformatted and amended to 16.12.20 NMAC, effective 10/15/12.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

8.307.7 NMAC, Benefit Package, filed 7-9-2008 is repealed and replaced by 8.307.7 NMAC, Benefit Package, effective 10-15-2012.

8.307.18 NMAC, CoLTS 1915 (C) Home and Community-Based Services Waiver, filed 11-29-2010 is repealed and replaced by 8.307.18 NMAC, CoLTS 1915 (C) Home and Community-Based Services Waiver, effective 10-15-2012.

8.312.2 NMAC, Nursing Facilities, filed 5-27-2010 is repealed and replaced by 8.312.2 NMAC, Nursing Facilities, effective 10-15-2012.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, filed 2-15-2007 is repealed and replaced by 8.314.5 NMAC, Developmental Disabilities Home and Community Based Services Waiver, effective 11-1-2012.

8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 3-15-11 is repealed and replaced by 8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, effective October 15, 2012.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 7 BENEFIT PACKAGE

8.307.7.1 ISSUING AGENCY: Human Services Department (HSD)

[8.307.7.1 NMAC - Rp, 8.307.7.1 NMAC, 10-15-12]

8.307.7.2 SCOPE: This rule applies to the general public.

[8.307.7.2 NMAC - Rp, 8.307.7.2 NMAC, 10-15-12]

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

[8.307.7.3 NMAC - Rp, 8.307.7.3 NMAC, 10-15-12]

8.307.7.4 DURATION: Permanent

[8.307.7.4 NMAC - Rp, 8.307.7.4 NMAC, 10-15-12]

8.307.7.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.

[8.307.7.5 NMAC - Rp, 8.307.7.5 NMAC, 10-15-12]

8.307.7.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.

[8.307.7.6 NMAC - Rp, 8.307.7.6 NMAC, 10-15-12]

8.307.7.7 DEFINITIONS: See 8.307.1.7 NMAC.

8.307.7.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.307.7.8 NMAC - Rp, 8.307.7.8 NMAC, 10-15-12]

8.307.7.9 BENEFIT PACKAGE: The medical assistance division (MAD) benefit package for the coordination of long-term services managed care organization (MCO) and the statewide behavioral health single entity (SE) shall each be paid fixed per-member-per-month payment rates. The MCO and SE shall cover these services. The MCO is responsible for covering the physical health services except as otherwise directed in this rule or by contract. The SE is responsible for covering the behavioral health services. The MCO and the SE shall not delete benefits from the MAD-defined benefit package. The MCO and SE must utilize service providers licensed in accordance with state and federal requirements to deliver services. MAD pays for medically necessary health care services for eligible recipients. For an eligible recipient also enrolled in medicare, the medicare replacement plan becomes the primary payer for services covered by medicare.

[8.307.7.9 NMAC - Rp, 8.307.7.9 NMAC, 10-15-12]

8.307.7.10 MEDICAL ASSISTANCE DIVISION PROGRAM POLICY MANUAL: The human services department (HSD) or its designee must review and approve the CoLTS MCO's UM protocols. Health care to New Mexico eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD through a CoLTS

managed care organization (MCO). MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. [8.307.7.10 NMAC - Rp, 8.307.7.10 NMAC, 10-15-12]

8.307.7.11 SERVICES INCLUDED IN THE COLTS 1915 (B) WAIVER PROGRAM BENEFIT PACKAGE:

A. Physical and behavioral health benefits that are available to full-benefit eligible recipient in the MAD fee-for-service (FFS) are covered for an eligible recipient enrolled in the CoLTS program. Refer to the benefit descriptions found in the MAD general benefit descriptions 8.301 NMAC; the medical and institutional services and providers found in 8.310 NMAC through 8.312, 8.314, 8.315, and 8.324 through 8.326 NMAC and as specified in the contract and the New Mexico state plan. Additional services are available under the CoLTS 1915 (b) waiver program to an eligible recipient when medically necessary. Refer to benefits descriptions found in 8.307 NMAC and as specified in the contract and CoLTS (b) waiver.

B. Physical and behavioral health benefits that are available to an early and periodic screening, diagnostic and treatment (EPSDT) eligible recipient in the MAD fee-for-service (FFS) are covered for an eligible recipient enrolled in the CoLTS program. Refer to the benefit descriptions found in 8.320 NMAC through 8.323 NMAC and as specified in the MCO contract and the New Mexico state plan. The EPSDT benefit package includes the delivery of the federally mandated EPSDT services. **Tot-to-teen health checks** The MCO shall adhere to the periodicity schedule and ensure that an eligible recipient receives EPSDT screens (tot-to-teen health checks), including:

(1) education of and outreach to an eligible recipient regarding the importance of health checks;

(2) development of a proactive approach to ensure that the services are received by an eligible recipient;

(3) facilitation of appropriate coordination with school-based providers;

(4) development of a systematic communication process with the MCO's network providers regarding screens and treatment coordination for an eligible recipient's condition;

(5) a process to document, measure and ensure compliance with the periodicity schedule; and

(6) development of a proactive process to ensure the appropriate follow-up of evaluations, referrals or treatment, especially early intervention for mental health conditions, vision and hearing screens, and current immunizations.

C. **Case management services:** The benefit package includes the following case management services:

(1) **case management services for eligible recipient pregnant women and their infants:** case management services provided to eligible recipient pregnant women up to 60 calendar days following the end of the month of the delivery, as set forth in 8.326.3 NMAC, *Case Managements Services for Pregnant Women and Their Infants*;

(2) **case management services for eligible recipient traumatically brain injured adults:** case management services provided to adult members (21 years of age or older) who are traumatically brain injured, as set forth in 8.326.6 NMAC, *Case Management Services for Traumatically Brain Injured Adults*;

(3) **case management services for eligible recipient children up to the age of three:** case management services provided to eligible recipient children up to the age of three who are medically at risk due to family conditions and not developmentally delayed, as detailed in 8.326.6 NMAC, *Case Management Services for Children Up to Age Three*;

(4) **case management services for the medically at risk:** case management services for eligible recipients who are under 21 and are medically at risk for physical or behavioral health conditions, as set forth in 8.320.5 NMAC, *EPSDT Case Management*; "medically at risk" is defined as those eligible recipients who have a diagnosed physical or behavioral health condition that has a high probability of impairing their cognitive, emotional, neurological, social, behavioral, or physical development;

(5) **case management services for eligible recipient adults with developmental disabilities:** case management services provided to eligible recipient adult members (21 years of age or older) who are developmentally disabled, as detailed in 8.326.2 NMAC, *Case Management Services for Adults with Developmental Disabilities*; and

(6) **case management services for the chronically mentally ill (SE only):** case management services provided to adults who are 18 years of age or older and who are chronically mentally ill, as detailed in 8.326.4 NMAC, *Case Management Services for the Chronically Mentally Ill*.

D. **Emergency services:** The benefit package includes emergency and post-stabilization care services for an eligible recipient. Emergency services are inpatient and outpatient services that are furnished by a qualified service provider and that are needed to evaluate or stabilize an emergency condition of an eligible recipient. An emergency condition shall meet the definition of emergency, as set forth in 8.307.1.7 NMAC, *definitions*. The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Emergency services shall be provided in accordance with Subsection F of 8.307.7.11 NMAC, *diagnostic imaging and therapeutic radiology services*. Post-stabilization care services are covered services related to an emergency condition that are provided after an eligible recipient is stabilized in order to maintain the stabilized condition or to improve or resolve the eligible recipient's condition, such that within reasonable medical probability, no material deterioration of the member's condition is likely to result from or occur during discharge of the eligible recipient or transfer of the eligible recipient to another facility.

E. **Health education and preventive services:** The MCO shall provide a continuous program of health education without cost to an eligible recipient. Such a program includes:

(1) publications, media, presentations, and classroom instruction;

(2) programs of wellness education;

(3) preventive service available to an eligible recipient; the MCO shall periodically remind and encourage an eligible recipient to use benefits, including physical examinations, that are available and designed to prevent illness;

(4) initiate targeted prevention initiatives for an eligible recipient with acute and chronic disease; and

(5) develop policies and procedures that encourage the proactive performance of home safety evaluations for all at-risk an eligible recipient transitioning from institutions to community settings.

F. **Inpatient hospital services:** The benefit package includes hospital inpatient acute care, procedures and services, as set forth in 8.311.2 NMAC,

Hospital Services. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the eligible recipient mother and the eligible recipient newborn. Health coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both the eligible recipient mother and the eligible recipient newborn.

G. **Pharmacy services:** The benefit package includes all pharmacy and related services, as set forth in 8.324.4 NMAC, *Pharmacy Services*.

(1) The MCO and the SE shall cover brand name drugs and drug items not generally on their formulary or PDL when determined to be medically necessary by the MCO or the SE or through an HSD fair hearing process or a MCO or SE appeal process. The MCO shall include on its formulary or PDL all covered multi-source generic drug items with the exception of items consisting of more than one therapeutic ingredient, anti-obesity items, and cough, cold and allergy medications; all of which may be limited to one or items at the discretion of the MCO. Items for cosmetic purposes or which are not medically necessary need not be on the PDL. The MCO shall reimburse family planning clinics, school-based health clinics, and DOH public health clinics for oral contraceptive agents and Plan B when dispensed to and eligible recipient and billed using HCPC codes and CMS 1500 claim forms. The MCO and the SE shall ensure that a Native American eligible recipient accessing the pharmacy benefit through an Indian health services or a tribal 638 pharmacy facility will be exempt from the preferred drug listing.

(2) The MCO shall use a PDL developed with consideration of the clinical efficiency, safety and cost effectiveness of drug items, and shall provide medically appropriate drug therapies for an eligible recipient. Drug items not on the PDL must be considered for coverage on a prior authorization basis. Upon development, the MCO will be required to deliver its pharmacy benefit package using a single MAD approved PDL.

(a) The MCO and the SE shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal requirements and state rules and statutes.

(b) The MCO and the SE shall coordinate the delivery of the pharmacy benefit when medicare part D is the primary coverage.

(c) The MCO shall ensure that any eligible recipient who takes nine or more different prescription medications has his or her medications reviewed by a medical clinician for appropriateness and the identification and correction of potentially harmful practices, and shall document this review in the eligible recipient's chart at least every six months.

(3) The MCO's preferred drug list (PDL) shall also use the following guidelines:

(a) there must be at least one representing drug for each of the therapeutic categories in the first data bank blue book;

(b) generic substitution shall be based on "AB" rating or clinical need;

(c) for a multiple source, brand name product within a therapeutic class, the MCO may select a representative drug;

(d) the PDL shall follow the centers for medicare and medicaid services (CMS) special guidelines relating to drugs used to treat HIV infection;

(e) the PDL shall include coverage of over the counter (OTC) drugs prescribed by a licensed practitioner as indicated in 8.324.4 NMAC *Pharmacy Services*; and

(f) the MCO shall implement an appeals process for service providers who believe that an exception to the PDL should be made for an eligible recipient.

H. **Pregnancy termination services:** The benefit package provides a pregnant eligible recipient coverage for a pregnancy termination under specific situations and based on these situations, reimbursement is made in accordance with 42 CFR Section 441.202 or through state-funding which is excluded from the capitation payment to the MCO. See 8.325.7 NMAC, *Pregnancy Termination.*

I. **Preventive health services:** The benefit package provides for an eligible recipient the following preventive health services.

(1) **Immunizations:** The MCO shall ensure that, within six months of enrollment, an eligible recipient is current with immunizations according to the type and schedule provided by the most recent version of the recommendations of the advisory committee on immunization practices (ACIP) of the centers for disease control and prevention, public health service, U.S. department of health and human services. This may be done by providing the necessary immunizations or by verifying the immunization history by a method deemed acceptable by the ACIP. "Current" is defined as no more than four months overdue.

(2) **Screens:** The MCO shall ensure that, to the extent possible, an asymptomatic eligible recipient receives and is current for at least the following screening services within six months of enrollment or within six months of a change in the standard. The MCO shall require its network providers to perform the appropriate interventions based on the results of the screens. "Current" is defined as no more than four months overdue. The MCO shall ensure that clinically appropriate follow-up or intervention is performed when indicated by the screening results.

(a) **Screening for breast cancer:** The benefit package provides for an eligible woman recipient age 50 and above who is not at high risk for breast cancer shall be screened annually with mammography and a clinical breast examination. An eligible female recipient of any age at high risk for developing breast cancer shall be screened as often as clinically indicated.

(b) **Screening for cervical cancer:** The benefit package provides for an eligible female recipient with a cervix to receive papanicolaou (PAP) testing starting at the onset of sexual activity, but at least by 18 years of age, and every three years thereafter, if prior testing has been consistently normal and the eligible recipient has been confirmed to be not at high risk. If the eligible recipient is at high risk, the testing frequency shall be at least annually.

(c) **Screening for colorectal cancer:** The benefit package provides for an eligible recipient age 50 and older at normal risk for colorectal cancer to be screened with annual fecal occult blood testing or sigmoidoscopy at a periodicity determined by the MCO.

(d) **Blood pressure measurement:** The benefit package provides for any eligible recipient to receive a blood pressure measurement as medically indicated.

(e) **Serum cholesterol measurement:** The benefit package provides for any eligible male recipient age 35 and above and for an eligible woman recipient age 45 and above who is at normal risk for coronary heart disease to receive serum cholesterol measurement every five years. An eligible recipient with multiple risk factors shall also receive HDL-C measurement.

(f) **Screening for obesity:** The benefit package provides for any eligible recipient to receive annual body weight and height measurements to be used in conjunction with a calculation of the body mass index or referenced to a table of recommended weights.

(g) **Screening for elevated lead levels:** The benefit package provides for an eligible recipient age nine to 15 months (ideally 12 months old) to receive a blood lead measurement at least once.

(h) **Screening for diabetes:** The benefit package provides for an eligible recipient to receive a fasting or two-hour post-prandial serum glucose measurement as medically indicated.

(i) **Screening for tuberculosis:** The benefit package provides for an eligible recipient to receive a tuberculin skin test based on the level of individual risk for development of the infection.

(j) **Screening for rubella:** The

benefit package provides for an eligible female recipient of childbearing age to be screened for rubella susceptibility by history of vaccination or by serology.

(k) **Screening for visual impairment:** The benefit provides for an eligible recipient three to four years of age to be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test.

(l) **Screening for hearing impairment:** The benefit package provides for an eligible recipient age 50 and older to be routinely screened for hearing impairment by questioning the eligible recipient about their hearing.

(m) **Screenings for alcohol and drug usage:** The benefit package provides for an eligible adolescent recipient and for an eligible adult recipient to receive at least one time an alcohol and drug screening. The screening may be conducted either by a careful review of the patterns of alcohol or drug utilization of the eligible recipient or by the use of a standardized screening questionnaire. These may include the alcohol use disorders identification test (AUDIT); the four-question CAGE instrument; or the substance abuse screening severity inventory (SASSI). The frequency of screening shall be determined by the results of the first screen and other clinical indications. An eligible recipient may be referred by his/her provider for or may self-refer for behavioral health services provided by the SE.

(n) **Prenatal screening:** The benefit package provides for an eligible recipient to be screened for preeclampsia, D (Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, and vaginal and rectal group B streptococcal infection; and counseled and offered testing for HIV.

(o) **Newborn screening:** The benefit package provides at a minimum, for an eligible newborn recipient to be screened for phenylketonuria, congenital hypothyroidism, galactosemia, and any other congenital disease or condition specified in accordance with department of health regulations, specifically 7 NMAC 30.6, *Newborn genetic screening program*.

(p) **Behavioral health screening:** The benefit package provides for an eligible recipient to be receive a behavioral health screening during an encounter with his/her primary care provider (PCP).

(3) **Non-behavioral health counseling services:** The benefit package provides for an asymptomatic eligible recipient, as applicable, to receive counseling and guidance on the following unless the eligible recipient's refusal is documented:

(a) prevention of tobacco use; promotion of physical activity;

(b) promotion of healthy diet;

(c) prevention of osteoporosis and heart disease, including a menopausal woman;

(d) prevention of motorized vehicle injuries;

(e) prevention of household and recreational injuries;

(f) prevention of dental and periodontal disease;

(g) prevention of HIV infection and other sexually transmitted diseases; and

(h) prevention of an unintended pregnancy.

(4) **Health advisor hotline:** The MCO shall provide a toll-free health advisor hotline, which shall provide at least the following:

(a) general health information on topics appropriate to the various MCO populations, including those with severe and chronic conditions;

(b) clinical assessment and triage to evaluate the acuity and severity of the eligible recipient's symptoms and make the clinically appropriate referral; and

(c) pre-diagnostic and post-treatment service decision assistance based on symptoms.

(5) **Family planning policy:** The MCO shall have a written family planning policy to ensure that eligible recipients of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to the following: methods of contraception; evaluation and treatment of infertility; risk reduction practices for HIV and other sexually transmitted diseases; options for pregnant eligible recipients.

(6) **Prenatal care program:** The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal services consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(a) educational outreach to any eligible female recipient of childbearing age;

(b) prompt and easy access to obstetrical services, including providing an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(c) risk assessment of every eligible pregnant recipient to identify high risk cases for special management;

(d) counseling that strongly advises voluntary testing for HIV;

(e) case management services to an eligible recipient of a high risk pregnancy to address special needs of the eligible pregnant recipient, especially if the risk is due to psychosocial factors such as substance abuse or a teen pregnancy;

(f) screening to determine the need of a post-partum home visit; and

(g) coordination with other services in support of good prenatal care, including transportation and other community services and referral to an agency that dispenses free or reduced price baby car seats.

J. **Reproductive health services:** The benefit package provides reproductive health services for an eligible recipient. See 8.325.3 NMAC, *Reproductive Health Services*.

(1) The MCO shall provide through its practitioners sufficient information to an eligible recipient to assist him/her make informed reproductive health decisions.

(2) An eligible female recipient shall have the right to self-refer to a woman's health specialist within the MCO's provider network for covered services necessary to provide routine and preventive reproductive health care services. This right of self-refer is in addition to the eligible recipient's designated source of primary care if that source is not a women's health specialist.

(3) The MCO will maintain a formal written family planning policy and ensure through its practitioners that an eligible recipient seeking family planning services will provide counseling (non-behavioral) and non-bias information pertaining to the following:

(a) methods of contraception, including sterilizations for an eligible male and a female recipient of childbearing age;

(b) the types of family planning services available;

(c) the eligible recipient's right to access these services in a timely and confidential manner;

(d) the freedom to choose a qualified family planning provider

(e) risk reduction practices for HIV infection and other sexually transmitted diseases; and

(f) counseling and non-bias information for pregnancy termination options, see 8.325.7 NMAC *Pregnancy Termination Procedures.*

K. **School-based services:** The benefit package provides an eligible recipient those services provided in schools, excluding those specified in the eligible recipient's individualized education plan (IEP) or individualized family service plan (IFSP), as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*.

L. **Service coordination:** The benefit package provides an eligible recipient service coordination that is person-centered and the intent is to support the eligible recipient pursue desired life outcomes by assisting him/her access support and services necessary to achieve the quality of life desired in a safe and healthy environment. Service coordination assists an eligible recipient gain access to needed coordination of CoLTS 1915 (b) and 1915 (c) waiver services and other necessary

services, regardless of the funding source.

M. **Transportation services:** The benefit package provides for an eligible recipient to access transportation services such as ground ambulance, air ambulance, taxicab or handivan, commercial bus, commercial air, meal, and lodging services, as indicated for medically necessary physical and behavioral health services, as set forth in 8.324.7 NMAC *Transportation Services*. In addition, the MCO must abide by New Mexico laws, statutes and regulations, specifically NMSA 1978 Section 65-2-97(F), stating that rates paid by the MCO to transportation providers are not subject to and are exempt from New Mexico public regulation commission approved tariffs. The MCO is also required to coordinate, manage and be financially responsible for the delivery of the transportation benefit to an eligible recipient receiving physical health services or behavioral health services.

[8.307.7.11 NMAC - Rp, 8.307.7.11 NMAC, 10-15-12]

8.307.7.12 [RESERVED]

8.307.7.13 COORDINATION WITH THE BEHAVIORAL HEALTH SINGLE ENTITY (SE):

A. The CoLTS MCO and the SE are to ensure an eligible recipient's physical and behavioral health services are coordinated and not duplicative. An eligible recipient enrolled in a 1915 (b) or (c) waiver program may access all appropriate MAD behavioral health services provided under the SE's contract. Under specific situations, the SE will be responsible for the service rather than the CoLTS MCO. The CoLTS MCO will:

(1) receive information from and provide information to the SE regarding an eligible recipient and a service provider;

(2) meet with the SE to resolve provider and recipient issues to improve services, communication and coordination;

(3) maintain and distribute statistical information and data as required under the MCO contract.

B. A behavioral health service rendered by a physical health provider will be covered by the MCO, even when the primary diagnosis is behavioral health subject to the MCO network/out of network provider requirements. Any payment for a service following medicare payment or payment by a medicare replacement plan is the responsibility of the CoLTS MCO, whether for behavioral health or physical health. Any services provided by a physical health service provider in an emergency room or in an inpatient setting will be covered by the CoLTS MCO.

C. Transportation services to a behavioral health service are the responsibility of the CoLTS MCO. The MCO will coordinate with the SE when providing transportation out of the eligible recipient's home community, such as out-of-home placement.

D. Laboratory services ordered by a behavioral health provider for an eligible recipient are the CoLTS MCO responsibility when:

(1) the lab work performed by an outside, independent laboratory or a non-behavioral health provider; the SE is responsible for lab work when performed by a behavioral health provider such as, a freestanding psychiatric hospital, a psychiatric unit, a psychiatric unit within a general hospital;

(2) the eligible recipient is under treatment in a freestanding psychiatric hospital.

E. Pharmacy benefits for an eligible recipient are the SE's responsibility under specific situations. The SE shall be responsible for payment of all drug items prescribed by a behavioral health provider, such as a psychiatrist, psychologist, psychiatric clinical nurse specialist, and a psychiatric nurse practitioner, certified to prescribe and contracted through the SE.

[8.307.7.13 NMAC - N, 10-15-12]

8.307.7.14 [RESERVED]

8.307.7.15 COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER: The following are services available to a MAD eligible recipient who is enrolled in the CoLTS 1915 (c) HCBS waiver. To be eligible for enrollment in the CoLTS 1915 (c) HCBS waiver program, a recipient must meet specific criteria, see long-term care services utilization review instructions for NF LOC. For additional information on the CoLTS 1915 (c) HCBS waiver**,** see 8.307.18 NMAC, *CoLTS 1915 (C) Home and Community Based Services Waiver.*

[8.307.7.15 NMAC - N, 10-15-12]

8.307.7.16 SERVICES EXCLUDED FROM THE COLTS 1915 (B) BENEFIT PACKAGE: For an eligible recipient enrolled in a CoLTS1915 (b) waiver program, the following are non-covered services:

A. services provided in intermediate care facilities for the mentally retarded (ICF/MR), as set forth in 8.313.2 NMAC, *Intermediate Care Facilities for the Mentally Retarded*;

B. emergency services to undocumented aliens, as set forth in 8.325.10 NMAC, *Emergency Services for Undocumented Aliens*;

C. experimental or investigational procedures, technologies or non-drug therapies, as set forth in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies*;

D. case management services provided by the children, youth and families department that are defined as child protective services case management, as set forth in 8.320.5 NMAC, *EPSDT Case Management*;

E. case management services provided by the aging and long-term services department, as set forth in 8.326.7 NMAC, *Adult Protective Services Case Management*;

F. case management services provided by the children, youth and families department, as set forth in 8.326.8 NMAC, *Case Management Services for Children Provided by Juvenile Probation and Parole Officers*;

G. services provided in the schools and specified in the IEP or IFSP, as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*; and

H. for an eligible recipient enrolled in a CoLTS 1915 (b) waiver program, the eligible recipient is not eligible to receive services provided through the following 1915 (c) waiver programs; these include:

(1) the disabled and elderly waiver;

(2) the developmentally disabled waiver;

(3) the AIDS waiver; and

(4) the medically fragile waiver.

[8.307.7.16 NMAC - Rp, 8.307.7.16 NMAC, 10-15-12]

8.307.7.17 VALUE ADDED OR ENHANCED SERVICES: See 8.307.1 NMAC, *General Provisions*.

[8.307.7.17 NMAC - Rp, 8.307.7.17 NMAC, 10-15-12]

HISTORY OF 8.307.7 NMAC:

History of Repealed Material:

8.307.7 NMAC, Benefit Package, filed 7-9-2008 - Repealed effective 10-15-2012. Replaced by 8.307.7 NMAC, Benefit Package, effective 10-15-2012.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 18 COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES WAIVER

8.307.18.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.307.18.1 NMAC - Rp, 8.307.18.1 NMAC, 10-15-12]

8.307.18.2 SCOPE: The rule applies to the general public.
[8.307.18.2 NMAC - Rp, 8.307.18.2 NMAC, 10-15-12]

8.307.18.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by HSD pursuant to state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.307.18.3 NMAC - Rp, 8.307.18.3 NMAC, 10-15-12]

8.307.18.4 DURATION: Permanent.
[8.307.18.4 NMAC - Rp, 8.307.18.4 NMAC, 10-15-12]

8.307.18.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.
[8.307.18.5 NMAC - Rp, 8.307.18.5 NMAC, 10-15-12]

8.307.18.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.307.18.6 NMAC - Rp, 8.307.18.6 NMAC, 10-15-12]

8.307.18.7 DEFINITIONS: [RESERVED]

8.307.18.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.307.18.8 NMAC - Rp, 8.307.18.8 NMAC, 10-15-12]

8.307.18.9 COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES WAIVER (CCW): To assist New Mexicans, the medical assistance division (MAD) administers the CoLTS 1915 (c) waiver (CCW). The CCW provides home and community-based services to eligible recipients who are disabled or elderly, as an alternative to institutional residency.
[8.307.18.9 NMAC - Rp, 8.307.18.9 NMAC, 10-15-12]

8.307.18.10 ELIGIBLE PROVIDERS:

A. Eligible independent providers and provider agencies must have been approved by MAD or its designee. The provider must have an approved MAD provider participation agreement with MAD or its designee.

B. Individual service providers participate as employees or contractors of approved agencies, except as otherwise recognized by these rules. Providers may subcontract only with individuals who are qualified and must follow the general contract provisions for subcontracting.

C. Providers are required to follow state licensing regulations, as applicable. This includes, but is not limited to nurses, social workers, physical therapists (PTs), physical therapy assistants (PTAs), occupational therapists (OTs), certified occupational therapy assistants (COTAs), and speech language pathologists (SLPs). Refer to the New Mexico regulation and licensing department for information regarding applicable licenses.

D. Once enrolled, providers receive information including medicaid program policies, and other pertinent materials from MAD. As MAD sends new materials, providers are responsible for ensuring they receive, read and adhere to information contained in the materials.

E. **Requirements for home health care agencies that provide private duty nursing and respite services through the waiver:**

(1) Services can be provided only through eligible agencies.

(2) Agencies must be licensed by the department of health (DOH) as a home health agency pursuant to state law.

(3) A provider must:

(a) comply with all applicable federal, and state waiver regulations regarding services;

(b) provide supervision to each respite staff at least quarterly including an on-site observation of the services provided and a face-to-face interview of the eligible recipient being served; and

(c) comply with the Department of Health Act, NMSA 1978, Section 9-7-1, et seq. and the Employee Abuse Registry Act, NMSA 1978, Sections 27-7A-1, et seq.

(4) Providers must have available and maintain a roster of trained and qualified employees for back-up of regular scheduling and emergencies.

(5) A provider must ensure that each staff meets the following requirements:

(a) completes a services training program that may include, but is not limited to, agency in-service training or continuing education classes and that all training is documented:

(i) new staff must complete 10 hours of training prior to providing services;

(ii) following the first year of service provision, staff must complete a minimum of 10 hours of training annually;

(iii) new staff must complete a written competency test that demonstrates the skill and knowledge required to provide services with a minimum passing score of 85 percent or better, prior to or within 30 days of providing services; and

(iv) staff assigned to new clients must receive instructions specific to the individual recipient prior to providing services to the recipient;

(b) possesses a minimum of one year experience as an aide in a hospital, nursing facility (NF) or rehabilitation center; or two years experience in managing a home or family;

(c) successfully passed nationwide criminal history screening pursuant to 7.1.9 NMAC and in accordance with the Caregivers Criminal History Screening Act, NMSA 1978, Section 29-17-1, et seq.; documentation that the screen has been successfully passed must be maintained in the employee's personnel file;

(d) a current tuberculin (TB) skin test or a chest x-ray upon initial employment by the provider as defined by the DOH; a copy of these results must be maintained in the employees personnel file;

(e) a current cardiopulmonary resuscitation (CPR)/heart saver certification; a copy of this certification must be maintained in the employee's personnel file;

(f) a current first aid certification; a copy of this certification must be maintained in the employee's personnel file; and

(g) a valid state driver's license and a motor vehicle insurance policy if the eligible waiver recipient is to be transported by staff; copies of the driver's license and motor vehicle insurance policy must be maintained in the employee's personnel file.

F. **Requirements for skilled maintenance therapy provider agencies:** Skilled maintenance therapy includes PT for adults, OT for adults, and speech and language therapy (SLT) for adults.

(1) Skilled maintenance therapy services must be provided by eligible skilled maintenance therapy agencies or

independent therapists.

(2) A physical, occupational and speech and language therapist and a physical therapist assistant (PTA) must possess a therapy license in their respective field from the New Mexico regulation and licensing department. A certified occupational therapist assistant (COTA) must possess an occupational therapy assistant certification from the New Mexico regulation and licensing department. A speech clinical fellow must possess a clinical fellow license from the New Mexico regulation and licensing department.

(3) Skilled maintenance therapy providers must:

(a) comply with all applicable federal and state waiver regulations and service standards regarding therapy services;

(b) ensure that all PTAs, COTAs and speech clinical fellows are evaluated by a licensed therapist supervisor licensed in the same field at least monthly in the setting where therapy services are provided; bi-monthly supervision must be provided;

(c) ensure all therapy services are provided under the order of the eligible waiver recipient's primary care provider; the therapy provider will obtain the order; the original of this order must be maintained by the therapy provider in the recipient's therapy file and the therapy provider must give a copy of the order to the service coordinator; and

(d) meet all other qualifications set forth in the CCW service standards.

G. **Requirements for assisted living facilities:**

(1) Assisted living services can be provided only by an eligible assisted living facility.

(2) An assisted living facility must:

(a) meet all the requirements and regulations, and be licensed by DOH as an adult residential care facility pursuant to 7.8.2 NMAC;

(b) provide a home-like environment; and

(c) comply with the provisions of Title II and III of the Americans with Disabilities Act (ADA) of 1990, (42 U.S.C. Section 12101, et seq.).

(3) An assisted living facility must:

(a) comply with all applicable federal, state and waiver regulations and service standards regarding services;

(b) ensure that individuals providing direct services meet all requirements for service provision; and

(c) ensure that individuals providing private duty nursing and skilled therapy services meet all requirements for these services if provided.

H. **Requirements for adult day health provider agencies:**

(1) Adult day health services can be provided only by eligible adult day health agencies.

(2) Adult day health facilities must be licensed by DOH as an adult day care facility.

(3) Adult day health facilities must meet all requirements and regulations set forth by DOH as an adult day care facility.

(4) An adult day health care provider agency must comply with the provisions of Title II and III of the Americans with Disabilities Act of 1990, (42 U.S.C. Section 12101 et seq.).

(5) An adult day health care provider agency must comply with all applicable city, county or state regulations governing transportation services.

I. **Requirements for environmental modifications providers:**

(1) Environmental modification services can be provided only by eligible environmental modification agencies.

(2) An environmental modification provider must have valid New Mexico regulation and licensing department, construction industries division, GB-2 class construction license pursuant to the Construction Industries Licensing Act NMSA 1978, Section 60-13-1 et seq.

(3) An environmental modification provider must:

(a) comply with all New Mexico state laws, rules, and regulations, including applicable building codes, and the laws and regulations of the Americans with Disability Act Accessibility Guidelines (ADAAG), the Uniform Federal Accessibility Standards (UFAS), and the New Mexico state building code; and

(b) provide at minimum a one-year warranty on all parts and labor.

J. **Requirements for emergency response providers:**

(1) Emergency response services can be provided only by eligible emergency response agencies.

(2) An emergency response provider must comply with all laws, rules and regulations of the New Mexico state public corporation commission for telecommunications and security systems, if applicable.

[8.307.18.10 NMAC - Rp, 8.307.18.10 NMAC, 10-15-12]

8.307.18.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. A MAD CCW provider must comply with all applicable federal regulations, MAD rules regarding the provision of covered waiver services and investigation requirements for providers of community based services pursuant to 7.1.13 NMAC or its successor.

D. Comply with DOH incident reporting.

E. Maintain a continuous quality management program with annual reports of the program implementation and outcomes. Reports must be submitted to MAD or its designee. See 8.302.1 NMAC, *General Provider Policies*.

[8.307.18.11 NMAC - Rp, 8.307.18.11 NMAC, 10-15-12]

8.307.18.12 ELIGIBLE RECIPIENTS:

A. CCW services are limited to the number of federally authorized unduplicated recipient (UDR) positions (slots) and program funding. Financial, non-financial and medical factors are used by HSD to determine an recipient's CCW eligibility. See: 8.200.400 NMAC through 8.200.500 NMAC, *Medicaid Eligibility-General Recipient Policies*, 8.290.500 NMAC through 8.290.600 NMAC, *Home and Community Based Waiver Services (Categories 090, 091, 092, 093, 094, 095, 096)* and long term care services utilization review instructions for nursing facility (NF) level of care (LOC) located on the HSD/MAD website.

B. CCW services are provided to an eligible recipient who is enrolled in the CCW program.

C. In addition to meeting eligibility criteria specified above, an eligible recipient must be elderly (age 65 or older), or have a disability (blind or disabled) as determined by the disability determination unit utilizing social security disability

guidelines, including duration and prognosis with respect to ability to be employed, and require a NF LOC or is currently residing in an institutional facility and is requesting a return to community living.

[8.307.18.12 NMAC - Rp, 8.307.18.12 NMAC, 10-15-12]

8.307.18.13 COVERED WAIVER SERVICES: The CCW covers the following services for a specified and limited number of MAD waiver eligible recipients as a cost effective alternative to institutionalization in a NF.

A. Service coordination operates independently within a CoLTS MCO using recognized professional standards adopted by the MCO and approved by the MAD, based on the service coordinator's independent judgment to support the needs of the eligible recipient and is structurally linked to the other MCO systems, such as quality assurance, recipient services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations. The MCO's service coordinator, who has experience in working with the elderly, individuals with disabilities, and others in need of long-term services, is responsible for ensuring that all applicable federal regulations and state rules involving service plan development are followed. Eligible service coordinator include: registered nurses (RN), licensed practical nurses (LPN), social workers, or individuals with at least a bachelor's degree in counseling, special education or a closely related field. Service coordination activities include **s**pecialized service management that is performed by a service coordinator, in collaboration with the eligible recipient or his personal representatives as appropriate, which are person-centered, and includes, but are not limited to:

(1) identification of the eligible recipient's needs, including physical health services, behavioral health services, social services, and long-term support services; and development of the eligible recipient's ISP or treatment plan to address those needs:

(2) assistance to ensure timely and coordinated access to an array of providers and services;

(3) attention to addressing unique needs of an eligible recipient; and

(4) coordination with other services delivered in addition to those noted in the ISP, as necessary and appropriate.

B. **Private duty nursing services for adults:** Private duty nursing services must be provided under the order and the direction of the eligible recipient's PCP. Eligible practitioners are RNs or LPNs. Services rendered are within the nurse's practice board scope of licensure, developed in conjunction with the interdisciplinary team and the eligible recipient's service coordinator.

(1) Private duty nursing services must be provided in accordance with all applicable federal regulations and state rules and service standards. Depending on the age of the eligible recipient, services may be covered under MAD's early periodic screening, diagnostic and treatment (EPSDT) services.

(2) Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness or chronic disability. Services include the following:

(a) medication management, administration and teaching;

(b) aspiration precautions;

(c) feeding tube management;

(d) gastrostomy and jejunostomy care;

(e) skin care and wound care;

(f) weight management;

(g) urinary catheter management and bowel and bladder care;

(h) health education;

(i) health screening;

(j) infection control and environmental management for safety;

(k) nutrition management;

(l) oxygen management;

(m) seizure management and precautions;

(n) anxiety reduction;

(o) staff supervision; and

(p) behavior supports and self-care assistance.

C. **Respite services:** Respite services are provided to an eligible recipient that is unable to care for him/herself and are furnished on a short term basis due to the absence or need for relief of the unpaid primary caregiver normally providing the care.

(1) Respite services may consist of non-nursing services or non-private duty nursing services, based on the eligible recipient's needs.

(2) Respite services may be provided in the eligible recipient's home, the respite provider's home, or the community.

(3) Services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities, and allowing community integration opportunities.

(4) Respite services are limited to a maximum of 100 hours annually per ISP year.

D. **Skilled therapy services for adults:** Skilled maintenance therapy services for adults include PT, OT and SLT services. Children receive these services through MAD EPSDT benefits.

(1) PT promotes gross and fine motor skills, facilitates independent functioning and works to prevent other progressive disabilities.

(a) Specific services may include:

(i) professional assessment(s), evaluations and monitoring for therapeutic purposes;

(ii) PT treatment interventions;

(iii) providing PT activity instruction to the eligible recipient;

(iv) usage of equipment and technologies while rendering a PT service to the eligible recipient;

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

(vi) the designing, modifying and monitoring the usage of related activities for use by the eligible recipient to support the ISP goals and objectives; and

(vii) with the approval of the eligible recipient, the therapist may consult and collaborate with other service providers and with the eligible recipient's caregivers.

(b) PT services must be provided in accordance with all applicable federal regulations and state and state and waiver rules.

(2) OT promotes fine motor skills, coordination, sensory integration, facilitates the use of adaptive equipment and assistive technology, facilitates independent functioning, and works to prevent other progressive disabilities.

(a) Specific services may include:

(i) teaching daily living skills instruction to the eligible recipient;

(ii) assisting the eligible recipient develop perceptual motor skills and sensory integrative functioning;

(iii) the designing, fabricating or modifying assistive technology or adaptive devices for use by the eligible recipient;

(iv) providing assistive technology services for use by the eligible recipient;

(v) the designing, fabricating or applying selected orthotic or prosthetic devices or selecting adaptive equipment for use by the eligible recipient;

(vi) utilizing the occupational therapist's specifically designed crafts and exercise to enhance the functioning of the eligible recipient;

(vii) providing OT activity training to the eligible recipient; and

(viii) with the approval of the eligible recipient, the therapist may consult and collaborate with other service providers and with the eligible recipient's caregivers.

(b) OT services must be provided in accordance with all applicable federal

regulations, state and waiver rules.

(3) SLT preserves abilities for independent function in communication, facilitates oral motor and swallowing function, facilitates use of assistive technology, and works to prevent other progressive disabilities.

(a) Specific services may include:

(i) identifying and assessing the communicative or oropharyngeal disorders and delays in the development of communication skills of the eligible recipient;

(ii) working to prevent other communicative or oropharyngeal disorders and delays in the development of communication skills;

(iii) developing and implementing the eligible recipient's eating or swallowing plans, monitoring their effectiveness, and adjusting the plans as necessary;

(iv) utilizing the therapist's specifically designed equipment, tools, and exercises to enhance the functioning of the eligible recipient;

(v) the designing, fabricating or modifying assistive technology or adaptive devices for use by the eligible recipient;

(vi) providing assistive technology services for use by the eligible recipient;

(vii) adapting the environment to meet the needs of the eligible recipient;

(viii) providing SLT activity training to the eligible recipient; and

(ix) with the approval of the eligible recipient, the speech and language therapist may consult and collaborate with other service providers or with the eligible recipient's caregivers.

(b) SLT services must be provided in accordance with all federal regulations, state and waiver rules and service standards.

E. **Assisted living services:** Assisted living is a residential service that includes assistance with activities of daily living (ADL) services, companion services, medication management (to the extent required under state law and medication oversight as required by state law), 24-hour on-site response capability to meet scheduled or unpredictable needs of the eligible recipient, and to provide supervision, safety and security services to the eligible recipient. Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision.

(1) Rates for room and board are excluded from the cost of services and are either billed separately by the provider or listed on an itemized statement that separates the costs of waiver services from the costs of room and board.

(2) Nursing and skilled therapy services are incidental, rather than integral to assisted living services. Nursing and skilled therapy services may be provided by third parties and must be coordinated with the assisted living facility.

(3) An assisted living facility must enter into an agreement with the eligible recipient that details all aspects of care to be provided including identified risk factors. The original agreement must be maintained in the eligible recipient's file and a copy must be provided by the assisted living facility to the eligible recipient's service coordinator.

(4) An assisted living facility must be provided by an assisted living facility that has been licensed and certified by DOH as an adult residential care facility, pursuant to 7.8.2 NMAC and all other applicable federal regulations, state and waiver rules.

F. **Adult day health services:** Adult day health services offer health and social services to assist an eligible recipient achieve optimal functioning and activates, motivates and rehabilitates the eligible recipient in all aspects of his or her physical and emotional well-being, based on the eligible recipient's specific needs.

(1) Services include:

(a) a variety of activities for an eligible recipient to promote personal growth and enhance the eligible recipient's self-esteem by providing opportunities to learn new skills and adaptive behaviors, improve capacity for independent functioning, or provide for group interaction in social and instructional programs and therapeutic activities; all activities must be supervised by program staff;

(b) supervision of self-administered medication;

(c) the eligible recipient's involvement in the greater community;

(d) transportation of the eligible recipient to and from the adult day health program; and

(e) meals that do not constitute a "full nutritional regime" of three meals per day.

(2) Services are generally provided for two or more hours per day on a regularly scheduled basis, for one or more days per week, through a MAD enrolled assisted living facility. Services must be provided as set forth by DOH pursuant to 7.13.2 NMAC.

(3) The provider must assure the inside and outside of its facility meets federal, state and waiver health and safety requirements.

(4) Adult day health services include nursing services and skilled maintenance therapies (OT/PT/SPT) that must be provided in a private setting at the eligible recipient's adult day health facility. The nursing and skilled maintenance therapies do not have to be directly provided by the facility. If directly provided, the facility must meet all federal regulations, state and waiver rules for the provision of these services.

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

(1) Adaptations include the following:

(a) installation of ramps and grab-bars;

(b) widening of doorways or hallways;

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

(d) purchase and installation of lifts or elevators;

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

(f) turnaround space adaptations;

(g) specialized accessibility, safety adaptations and additions;

(h) installation of trapeze and mobility tracks for home ceilings;

(i) purchase and installation of automatic door openers or doorbells, voice-activated, light-activated, motion-activated and electronic devices;

(j) fire safety adaptations;

(k) purchase and installation of modified switches, outlets or environmental controls for home devices;

(l) purchase and installation of alarm and alert systems or signaling devices;

(m) air filtering devices;

(n) heating/cooling adaptations; and

(o) glass substitute for windows and doors.

(2) Service coordinators must consider alternative methods of meeting the eligible recipient's needs prior to listing environmental modifications on the ISP.

(3) Environmental modifications have a limit of up to $5,000 every five years.

(4) The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction or remodeling services, provide administrative and technical oversight of construction projects, provide consultation to the eligible recipient's family members as appropriate, waiver providers and contractors concerning environmental modification projects to the eligible recipient's residence, and inspect

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

(5) The environmental modification provider must submit the following information:

(a) an environmental modification evaluation;

(b) a service cost estimate including equipment, materials, supplies, labor, travel, per diem;

(c) a letter of acceptance of service cost estimate signed by the eligible recipient;

(d) a letter of permission from owner of property;

(e) a construction letter of understanding detailing the work proposed;

(f) photographs of the proposed modification; and

(g) documentation demonstrating compliance with the American with Disabilities Act Accessibility Guidelines (ADAAG), the uniform federal accessibility standards (UFAS), and the New Mexico state building code.

(6) After the completion of work, the environmental modification provider must submit the following to the MCO:

(a) a letter of approval of work completed, signed by the eligible recipient; and

(b) photographs of the completed modifications.

(7) Environmental modification services must be managed by professional staff available to provide technical assistance and oversight for environmental modification projects.

(8) Environmental modification services shall be provided in accordance with all applicable federal regulations, state and waiver rules.

H. **Emergency response services:** Emergency response services provide an electronic device that enables an eligible recipient to secure help in an emergency.

(1) Emergency response services include:

(a) testing and maintaining equipment;

(b) training to the eligible recipient, caregivers and first responders on use of the equipment;

(c) 24 hour monitoring for alarms;

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

(2) The response center must be staffed by trained professionals.

(3) Emergency response service categories are emergency response and emergency response high need.

(4) An emergency response provider shall provide the eligible recipient with information regarding services rendered, limits of services and information regarding agency service contracts.

(5) The emergency response center will provide within 24 hours a report to the eligible recipient's CoLTS MCO all emergencies and changes in the eligible recipient's condition that may affect service delivery, complete and submit a quarterly report to the eligible recipient's MCO, of which the original report must be maintained in the eligible recipient's.

(6) Emergency response services shall be provided in accordance with all applicable federal regulations, state and waiver rules.

(7) The eligible recipient may also wear a portable "help" button to allow for mobility. The system is connected to the eligible recipient's phone and programmed to signal a response center when a "help" button is activated. The response center reacts to the signal to ensure the eligible recipient's health and safety.

I. **Service coordination:** Service coordination operates independently within the MCO using recognized professional standards adopted by the MCO and approved by MAD, based on the service coordinator's independent judgment to support the needs of the eligible recipient and is structurally linked to the other MCO systems, such as quality assurance, eligible recipient services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations. The MCO's service coordinator, who has experience in working with the elderly, individuals with disabilities, and others in need of long-term services, is responsible for ensuring that all applicable federal regulations, state and waiver rules and CCW services standards involving service plan development are followed. Service coordinators can be RNs, LPNs, social workers, or individuals with at least a bachelor's degree in counseling, special education or a closely related field. Service coordination activities include **s**pecialized service management that is performed by a service coordinator, in collaboration with the eligible recipient or the eligible recipient's family or representatives as appropriate, which are person-centered, and includes, but is not limited to:

(1) identification of the eligible recipient's needs, including physical health services, behavioral health services, social services, and long-term support services; and development of the eligible recipient's ISP or treatment plan to address those needs;

(2) assistance to ensure timely and coordinated access to an array of providers and services;

(3) attention to addressing unique needs of the eligible recipient; and

(4) coordination with other services delivered in addition to those noted in the ISP, as necessary and appropriate.

J. **Community transition goods and services:**

(1) CCW community transition goods and services: These are non-recurring set-up expenses for an eligible recipient who is transitioning from a qualified institution to a qualified community setting. In order to be eligible for this service, the eligible recipient must have a minimum 30-calendar day NF stay prior to transition to his/her community. Allowable expenses are those necessary to enable the eligible recipient to establish a basic household that do not constitute room and board and may include:

(a) security deposits that are required to obtain a lease on an apartment or home where the eligible recipient will reside;

(b) essential household furnishings required to occupy the eligible recipient's residence including furniture, window coverings, food preparation items, and bed/bath linens;

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

(d) services necessary for the eligible recipient's health and safety such as pest eradication and one-time cleaning prior to occupancy;

(e) moving expenses related to the eligible recipient's change of residence;

(f) within 180 calendar days prior to the eligible recipient's occupancy of the new residence, necessary home environmental modifications to support the eligible recipient;

(g) specialized medical equipment and supplies not otherwise covered by MAD and purchased within 60 days of the scheduled transition;

(h) assistive technology and durable medical equipment not otherwise covered by MAD purchased within 60 calendar days of the scheduled transition;

(i) nutrition support services such as short-term nutritional counseling and education in food preparation skills;

(j) non-medical transportation;

(k) non-medical transportation supports such as vehicle modification;

(l) family services to support or educate the informal support network; and

(m) the purchase and related costs of service dogs up to service limits.

(2) Community transition goods and services are furnished only to the extent that the goods or services:

(a) are reasonable and necessary as determined through the service plan development process;

(b) are clearly identified in the service plan;

(c) cannot be obtained from other sources;

(d) are not prohibited by federal

regulations and state rules and service standards;

(e) are not experimental in nature; and

(f) the eligible recipient has no other access to these services.

(3) Community transition goods and services do not include monthly rental or mortgage expense, food, regular utility charges, or household appliances or items that are intended for purely diversion/ recreation purposes.

(4) CCW community transition goods and services are limited to $3,500.00 per person every five years. In order to be eligible for this service, the eligible recipient must have a minimum of a 30-calendar day NF stay prior to transitioning to his/her community. The individual's eligibility status as an eligible recipient must be verified prior to discharge from the NF. CCW transition goods and services are limited to an eligible recipient who has established medicaid eligibility prior to discharge from the NF or qualifying facility.

K. **Community relocation specialist services:** The CoLTS MCO is responsible for the designation and the oversight of the community transition relocation specialist (CTRS). CTRS services are specialized services, provided while the eligible recipient is in a NF and at a minimum, during the first 60 calendar days of the transition period.

(1) The CTRS must assess the eligible recipient's needs, complete a service plan, assist the eligible recipient arrange for and procure needed resources for the move from the NF to the community, and monitor transition service delivery. The CTRS provides the eligible recipient information on MAD's home and community-based service options, its transition process, and other relevant issues. The CTRS works with the eligible recipient, his support network when applicable, and his MCO service coordinator to develop a person-centered, community-based transition plan. This plan includes a detailed transition plan and budget, and is as part of the eligible recipient's ISP.

(2) The CTRS and the eligible recipient in the NF work together to ensure that the needed services, goods and supports are in place prior to the eligible recipient's move. The CTRS is to ensure the caregiver has specific education to provide the necessary services to the eligible recipient. The CTRS works with the MCO service coordinator to ensure transition services are included in the comprehensive ISP and are implemented and monitored by the service coordinator.

(3) The CTRS must provide services for an eligible recipient:

(a) a minimum of 60 calendar days if institutionalized for six or more months; or

(b) a minimum of 14 calendar days if institutionalized for less than six months;

(c) services are limited to 10 hours or up to $500 per transition per eligible recipient;

(d) services are limited to no more than 180 calendar days prior to transition from the NF to the community; and

(e) services are limited to no more than 60 calendar days following transition from the NF to the community.

[8.307.18.13 NMAC - Rp, 8.307.18.13 NMAC, 10-15-12]

8.307.18.14 NON-COVERED SERVICES: A CCW eligible recipient receives full state plan medicaid benefits in addition to the CCW services listed as covered waiver services in this rule. MAD does not cover room and board as a waiver service or as ancillary services. See 8.301.3 NMAC, *General Noncovered Services* for an overview of non-covered services.

[8.307.18.14 NMAC - Rp, 8.307.18.14 NMAC, 10-15-12]

8.307.18.15 INDIVIDUALIZED SERVICE PLAN (ISP): An ISP must be developed by an interdisciplinary team of professionals in collaboration with the eligible recipient and others involved in the eligible recipient's care. The ISP must be in accordance with the CCW service standards.

A. The interdisciplinary team must review the ISP at least every six months or more often if indicated.

B. The individualized services plan must contain the following information:

(1) a statement of the nature of the specific problem and the specific needs of the eligible recipient;

(2) a description of the functional level of the eligible recipient;

(3) a statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(4) a description of intermediate and long-range goals for the eligible recipient, with a projected timetable for their attainment and the duration and scope of services;

(5) a statement and rationale of the ISP for achieving the eligible recipient's intermediate and long-range goals, including provision for review and modification of the eligible recipient's plan;

(6) the specification of responsibilities for areas of care, description of needs, and orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the eligible recipient; and

(7) a person-centered service plan for community-based transition benefits, services and budget for a recipient eligible for such benefits and services.

[8.307.18.15 NMAC - Rp, 8.307.18.15 NMAC, 10-15-12]

8.307.18.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews by medicaid or its designee may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, CCW providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior authorization:** To be eligible for CCW services, recipients must meet the LOC requirements for services provided in a NF. LOC determinations are made by medicaid or its designee. The ISP must specify the type, amount and duration of services. All services specified in the ISP require prior authorization from medicaid or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid and CCW services or other health insurance prior to the time services are furnished. Recipients may not be institutionalized, or hospitalized, or receive other HCBS waiver services at the time CCW services are provided with the exception of transition goods and services and relocation specialist services. See 8.290.400.10 NMAC, *basis for defining the group*.

C. **Reconsideration:** Providers who disagree with the denial of a prior authorization request or other review decisions may request a re-review and reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [8 NMAC 4.MAD.953].

[8.307.18.16 NMAC - Rp, 8.307.18.16 NMAC, 10-15-12]

8.307.18.17 REIMBURSEMENT: Once enrolled, agencies receive instructions on documentation, billing, and claims processing. Claims must be filed per the billing instructions in the medicaid policy manual for FFS or by the CoLTS MCO in managed care. Providers must follow all medicaid billing instructions. FFS reimbursement to providers of waiver services is made at a predetermined reimbursement rate. See 8.302.2 NMAC, *Billing For Medicaid Services.*

[8.307.18.17 NMAC - Rp, 8.307.18.17 NMAC, 10-15-12]

HISTORY OF 8.307.18 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center.
ISD-Rule 310.2000, Coordinated Community In-Home Care Services, 3/19/84.

History of Repealed Material:
ISD-Rule 310.2000, Coordinated Community In-Home Care Services, Repealed 1/18/95.
8 NMAC 4.MAD.733, Disabled and Elderly Home and Community-Based Services Waiver, filed 1/10/97 - Repealed effective 8/1/2006.
8.314.2 NMAC, Disabled and Elderly Home and Community-Based Services Waiver, filed 7/18/2006 - Repealed effective 12-15-2010.
8.307.18 NMAC, CoLTS 1915 (c) Home and Community-Based Services Waiver, filed 11-29-2010 - Repealed effective 10-15-2012.

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 312 LONG TERM CARE SERVICES - NURSING SERVICES
PART 2 NURSING FACILITIES

8.312.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.312.2.1 NMAC - Rp, 8.312.2.1 NMAC, 10/15/12]

8.312.2.2 SCOPE: The rule applies to the general public.
[8.312.2.2 NMAC - Rp, 8.312.2.2 NMAC, 10/15/12]

8.312.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.312.2.3 NMAC - Rp, 8.312.2.3 NMAC, 10/15/12]

8.312.2.4 DURATION: Permanent
[8.312.2.4 NMAC - Rp, 8.312.2.4 NMAC, 10/15/12]

8.312.2.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.
[8.312.2.5 NMAC - Rp, 8.312.2.5 NMAC, 10/15/12]

8.312.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.312.2.6 NMAC - Rp, 8.312.2.6 NMAC, 10/15/12]

8.312.2.7 DEFINITIONS: [RESERVED]

8.312.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.312.2.8 NMAC - Rp, 8.312.2.8 NMAC, 10/15/12]

8.312.2.9 NURSING FACILITIES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for services furnished in nursing facilities.
[8.312.2.9 NMAC - Rp, 8.312.2.9 NMAC, 10/15/12]

8.312.2.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. nursing facilities (NF) which:

(1) are currently licensed and certified by the department of health (DOH) to meet MAD nursing facility conditions of participation; see 42 CFR Part 483, as amended;

(2) comply with the MAD recipients' personal funds rules;

(3) comply with the MAD utilization review process and agree to operate in accordance with all MAD rules, including the performance of discharge planning;

(4) comply with the MAD rules for the pre-admission screening and resident review (PASRR) of mentally ill and intellectually disabled program;

(5) ensure the required nurse aide training is implemented; and

(6) ensure that facilities with 60 or more MAD beds certify a minimum of four distinct beds in the medicare program;

B. the above requirements can be waived if the NF meets one of the following conditions:

(1) the NF is located in a rural area and is unable to attract therapists as required by the medicare program; for a waiver to be granted under this condition, the provider must prove that good faith efforts to hire or contract with the required therapists have been made;

(2) the NF has obtained a waiver of the RN staffing requirement from DOH, in accordance with applicable federal regulations; or

(3) the NF is one of two or more NFs in the same town owned or operated by the same owner/manager and one of the other facilities is medicare-certified; in addition, the NF must demonstrate on a yearly basis that the waiver does not hinder access to medicare part A services for medicaid-eligible recipients and that the facility is using, to the best of its ability, corridor billings to medicare for part B services(s); if medicare removes the ability to do corridor billing, the waiver automatically ceases;

(a) any requests for a waiver must contain sufficient documentation to support the request and must be submitted in writing to MAD;

(b) medicare is the primary payer for NF services covered under the medicare program;

C. services must be provided within the scope of the practice and licensure for each provider; and must be in compliance with the statutes, rules and regulations of the applicable practice and with the MAD program policy manual.

[8.312.2.10 NMAC - Rp, 8.312.2.10 NMAC, 10/15/12]

8.312.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

See 8.302.1 NMAC, *General Provider Policies*.

[8.312.2.11 NMAC - Rp, 8.312.2.11 NMAC, 10/15/12]

8.312.2.12 REQUIRED NURSING FACILITY SERVICES: Nursing facilities are required to provide the following to a MAD eligible recipient resident:

A. room and board;

B. professional nursing services 24 hours a day, seven days a week; professional nursing services are those services which are performed directly by a registered nurse (RN) or a licensed practical nurse (LPN), under the direction of a medical practitioner;

C. services of an RN on an eight hours a day, seven days a week basis, and at least the services of a LPN at all other times; and

D. personal assistance services on a 24 hours a day, seven days a week basis; personal assistance services are those services, other than professional nursing services, that are provided to an eligible recipient who, because of age, infirmity, physical or behavioral health limitations, requires assistance to accomplish activities of daily living.

[8.312.2.12 NMAC - Rp, 8.312.2.12 NMAC, 10/15/12]

8.312.2.13 COVERED SERVICES:

A. MAD covers NF services identified as allowable costs. See 8.312.3 NMAC, *Cost Related Reimbursement of Nursing Facilities*.

B. MAD covers physical, occupational and speech therapy services furnished to an eligible recipient residing in a NF in the following manner:

(1) if the eligible recipient is also eligible for medicare and the facility does part B billing, the co-payment or deductible is processed by MAD for services is paid by MAD;

(2) if the eligible recipient receives high NF level services, services are included in the MAD facility rate; or

(3) if eligible, the recipient receives low NF level services, services are billed separately by participating therapy providers.

[8.312.2.13 NMAC - Rp, 8.312.2.13 NMAC, 10/15/12]

8.312.2.14 NONCOVERED SERVICES: NF services are subject to the limitations and coverage restrictions which exist for other MAD services. See also 8.301.3 NMAC, *General Noncovered Services*; 8.312.3.11 NMAC, *determination of actual, allowable and reasonable costs and setting of prospective rates*; and 8.324.4 NMAC, *Pharmacy Services*, for covered pharmacy services which are billed directly by pharmacy providers.

[8.312.2.14 NMAC - Rp, 8.312.2.14 NMAC, 10/15/12]

8.312.2.15 RECIPIENT PERSONAL FUND ACCOUNTS:

A. As a condition for MAD provider participation, each NF must establish and maintain an acceptable system of accounting for a MAD eligible recipient resident's personal funds when a MAD eligible recipient requests that his or her personal funds be cared for by the facility. See 42 CFR Section 483.10(c). See Subsection D of 7.9.2.22 NMAC.

(1) Requests for a NF to care or not care for an eligible recipient resident's funds must be made in writing and secured by a request to handle recipient funds form or letter signed by the eligible recipient or his or her authorized representative. The form or letter is kept in the eligible recipient's file at the facility.

(2) An eligible recipient's personal fund consists of a monthly maintenance allowable, established by MAD. If the eligible recipient resident receives any income in excess of this allowance, the excess is applied to the cost of the eligible recipient resident's medical care at the facility. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) A NF must have procedures on the handling of eligible recipient residents' funds. These procedures must not allow the facility to commingle eligible recipient residents' funds with facility funds.

(4) A NF should use these applicable federal regulations and state rules to develop procedures for handling resident funds.

(5) An eligible recipient resident has the right to manage his/her financial affairs and no facility can require an eligible recipient resident to deposit his/her personal funds with the facility.

(6) A NF must purchase a surety bond or furnish self-insurance to ensure the security of all personal funds deposited with the facility.

(7) Failure of a NF to furnish an acceptable accounting system constitutes a deficiency that must be corrected by the provider and verified by DOH survey teams.

B. **Fund custodians:** A NF must designate a full-time employee and an alternate to serve as fund custodians for handling an eligible recipient resident's money on a daily basis. See Subsection D of 7.9.2.22 NMAC.

(1) Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(a) reconcile balances of each eligible recipient's accounts with the collective bank account;

(d) periodically audit and reconcile the petty cash fund; and

(c) authorize checks for the withdrawal of funds from the bank account.

(2) A NF must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each resident's personal funds entrusted to facilities on the eligible recipient resident's behalf.

C. **Bank account:** A NF must establish a bank account for the deposit of all money for each eligible recipient resident who requests the NF to handle his or her funds. An eligible recipient's personal funds are to be held separately and not commingled with the NF funds. See Subsection D of 7.9.2.22 NMAC.

(1) A NF must deposit an eligible recipient resident's personal funds of more than $50 dollars in an interest bearing account that is separate from any of the NF operating

accounts and which credits all interest earned on the eligible recipient resident's account to that account. An eligible recipient resident must have convenient access to these funds.

(2) A NF must maintain an eligible recipient resident's personal funds up to $50 in an interest bearing account or a petty cash fund that is separate from any of the NF operating accounts. An eligible recipient resident must have convenient access to these funds.

(3) Individual financial records must be available on the request of an eligible recipient resident or his or her legal representative.

(4) Within 30 calendar days of the death of an eligible recipient resident whose personal funds are deposited with the facility, a NF must convey the deceased eligible recipient resident's funds and a final accounting of these funds to the individual or probate jurisdiction administering the deceased eligible recipient resident's estate.

D. **Establishment of individual accounts:** A NF must establish accounts for each eligible recipient resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file or looseleaf binder. See Subsection D of 7.9.2.22 NMAC.

(1) For money received, the source, amount and date must be recorded. The NF must provide the eligible recipient resident or his/her representative receipts for the money. The NF retains a copy of the deposit in the eligible recipient resident's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of an eligible recipient resident must be recorded. All money spent either on behalf of the eligible recipient resident or withdrawn by the eligible recipient resident or his/her representative must be validated by receipts or signatures on each eligible recipient resident's individual ledger sheet.

(3) The NF must notify each eligible recipient resident when the account balance is $200 less than the supplemental security income (SSI) resource limit for one person specified in section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the eligible recipient resident's other nonexempt resources reach the SSI resource limit for one person, the eligible recipient resident can lose eligibility for medicaid or SSI.

E. **Personal fund reconciliation:** The NF must balance each eligible recipient resident's individual accounts, the collective bank accounts and the petty cash fund at least once each month. The NF must furnish each eligible recipient resident or his/her representative with an accounting of the eligible recipient residents' funds at least quarterly. Copies of each eligible recipient resident's individual account records can be used to furnish this information. See Subsection D of 7.9.2.22 NMAC.

F. **Petty cash fund:** The NF must maintain a cash fund in the facility to accommodate the small cash requirements of an eligible recipient resident. Five dollars or less per each eligible recipient resident may be adequate. The amount of money kept in the petty cash fund is determined by the number of NF residents using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund. See Subsection D of 7.9.2.22 NMAC.

(1) To establish the fund, the NF must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:

(a) an eligible recipient resident or his/her authorized representative request small amounts of spending money;

(b) the amount disbursed is entered on each eligible recipient resident's individual ledger record; and

(c) the eligible recipient resident or his/her representative signs an account record and receives a receipt.

(3) To replenish the petty cash fund, the following procedures should be used.

(a) The money left in the cash box is counted and added to the total of all disbursements made since the last replenishment; and the total of the disbursements plus cash on hand equals the beginning amount.

(b) Money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures should be used once each month:

(a) count money at hand; and

(b) total cash disbursed either from receipts or each eligible recipient resident's individual account records; the cash on hand plus total disbursements equals petty cash total.

(5) To close each eligible recipient resident account, the NF should do the following:

(a) enter date of and reason for closing the account;

(b) write a check against the collective bank account for the balance shown on each eligible recipient resident's individual account record;

(c) get signature of the eligible recipient resident or his/her authorized representative on the eligible recipient resident's individual account record, as receipt of payment; and

(d) notify the local ISD office if closure is caused by death of an eligible recipient resident so that prompt action can be taken to terminate assistance; within 30 days of the death of an eligible recipient resident who has no relatives, the NF conveys the eligible recipient resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the resident's estate; see 42 CFR Section 483.10(c)(6).

G. **Retention of records:** All account records are retained for at least six years or, in case of an audit, until the audit is completed.

H. **Non-acceptable uses of residents' personal funds:** Non-acceptable uses of an eligible recipient resident's personal funds include the following:

(1) payment or charges for services or items covered by MAD or medicare specified as allowable costs; see 8.312.3.11 NMAC, *determination of actual, allowable and reasonable costs and setting of prospective rates*;

(2) difference between the NF's billed charge and the MAD payment; and

(3) payment for services or supplies routinely furnished by the NF, such as linens or nightgowns;

(4) a NF cannot impose charges against eligible recipient resident's personal funds for any item or service for which payment is made by MAD or for any item the eligible recipient resident or his/her representative did not request;

(5) a NF must not require eligible recipient resident or his/her representative to request any item or service as a condition of admission or continued stay;

(6) a NF must inform an eligible recipient resident or his/her representative who requests noncovered items or services that there is a charge for the item and the amount of the charge.

I. **Monitoring of residents' personal funds:** NFs must make all files and records involving an eligible recipient resident's personal funds available for inspection by authorized state or federal auditors. DOH survey teams verify that a NF has established systems to account for an eligible recipient resident's personal funds, including the components described above. Failure to furnish an acceptable accounting system constitutes a deficiency that must be corrected. See Subsection D of 7.9.2.22 NMAC.

[8.312.2.15 NMAC - Rp, 8.312.2.15 NMAC, 10/15/12]

8.312.2.16 RESERVE BED DAYS: MAD pays to hold or reserve a bed for an MAD eligible recipient resident in a NF to allow for the eligible recipient resident to make a brief home visit, for acclimation to a new environment, or for hospitalization according to the limits and conditions

outlined below.

A. **Coverage of reserve bed days:** MAD covers six reserve bed days per calendar year for every long term care eligible recipient resident for hospitalization without prior approval. MAD covers three reserve bed days per calendar year for a brief home visit without prior approval. MAD covers an additional six reserve bed days per calendar year with prior approval to support a MAD eligible recipient resident to adjust to a new environment as part of the discharge plan.

(1) An eligible recipient resident's discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.

(2) The prior approval request must include the eligible recipient resident's name, medicaid identification number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the eligible recipient resident during the visit or placement and a written medical order for trial placement.

B. **Documentation of reserve bed days:** When an eligible recipient resident is discharged from a NF for any reason, appropriate documentation must be placed in the eligible recipient resident's chart. A medical order must be obtained if the eligible recipient resident is hospitalized, requests a home visit or a trial placement.

C. **Level of care determinations:** A new level of care determination must be performed by the MAD utilization review (UR) contractor if an eligible recipient resident is gone from the NF for more than three midnights. An abstract must be completed, including information on the reason for the eligible recipient resident's absence, outcome of the leave and any other pertinent information concerning the leave.

D. **Reimbursement and billing for reserve bed days:** Reimbursement for reserve bed days to the NF is limited to the rate applicable for the level of care medically necessary for the eligible recipient resident, as determined and approved by MAD or its designee. The reserve bed day reimbursement is equal to 50 percent of the regular payment rate for MAD fee-for-service or as otherwise negotiated between the NF provider and the MAD designated contractor. Billing for reserve bed days is based on the nursing census, which runs from midnight to midnight. MAD or its designated contractor, pays for the admission day but not for the discharge day.

[8.312.2.16 NMAC - Rp, 8.312.2.16 NMAC, 10/15/12]

8.312.2.17 LEVEL OF CARE DETERMINATION: Medical necessity, level of care, and length of stay determinations are carried out in accordance with MAD utilization review (UR) policy and procedures, as authorized under Title XIX of the Social Security Act. See 8.302.5 NMAC, *Prior Authorization and Utilization Review,* and 8.350.4 NMAC, *Reconsideration of Audit Settlements.*

[8.312.2.17 NMAC - Rp, 8.312.2.17 NMAC, 10/15/12]

8.312.2.18 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) OF MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS: As part of the initial abstract for a new admission or as part of a subsequent specified review as determined by PASRR, or a significant change review as indicated by the minimum data set (MDS) for an eligible recipient resident with identified mental illness or intellectually challenged, the NF must complete a level I PASRR screening. See Omnibus Reconciliation Acts of 1987 and 1990 as codified at 42 CFR Section 483.100 Subpart C. See also P.L. 104-315 which amends title XIX of the Social Security Act effective October 19, 1996. This requirement applies to all applicants or residents, regardless of payment source.

A. **Pre-admission screens not required:** Pre-admission screens do not need to be performed on the following eligible recipient resident:

(1) when admitted from the hospital whose attending physicians certify before admission to the NF that the eligible recipient resident is likely to require NF care for less than 30 days (as determined by PASRR review of the his or her level I screen data prior to NF admission);

(2) when readmitted to NFs from hospitals to which he/she was transferred for the purpose of receiving care; and

(3) when transferred from one NF to another without an intervening hospital stay.

B. **Purpose of the screens:** The purpose of the PASRR screen is to determine whether residents have a mental illness or an intellectual disability, need the level of services furnished in a NF and need specialized services based on the mental illness or intellectual disability. A NF performs the level I screen which identifies an eligible recipient resident who has a mental illness or an intellectual disability. When an eligible recipient resident is identified, the NF refers him or her to the developmental disabilities division of DOH for a PASRR level II evaluation.

C. **Level II screen determination:** The PASRR level II screen determines the following:

(1) the eligible recipient resident's total needs are such that his or her needs can be met in an appropriate community setting;

(2) the eligible recipient resident's total needs are such that they can be met only on an inpatient basis, which can include the option of placement in a home and community-based service waiver program, but for which inpatient care is necessary;

(3) if inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs; or

(4) if inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the eligible recipient resident's needs, another setting, such as an intermediate care facility for the intellectually disabled can be indicated.

D. **Right to an administrative hearing:** Residents who believe that an erroneous determination was made with regard to the PASRR can request administrative hearings. See 8.354.2 NMAC, *PASRR and Patient Status Hearings,* for more information. The NF must provide notice to an eligible recipient resident of proposed transfers or changes of status. The notice must inform an eligible recipient resident of his or her right to request a hearing, the method by which a hearing can be requested and his or her right to present evidence in person or through representatives. An eligible recipient resident who requests a hearing has 90 calendar days after the date of the notice to request a hearing. Within 60 days of receipt of the request for a hearing, the hearing is conducted, decisions reached and notice furnished to the eligible recipient resident and the NF.

E. **Restriction on reimbursement for medicaid residents:** A NF is not reimbursed for any service furnished to an eligible recipient resident when pre-admission screens, subsequent specified reviews or significant change reviews are not performed in a timely manner. MAD pays only for services furnished after the screens or reviews are performed and will recoup amounts paid to a NF during periods of noncompliance. MAD payment for services does not begin until a Level II screening has been performed, if applicable.

[8.312.2.18 NMAC - Rp, 8.312.2.18 NMAC, 10/15/12]

8.312.2.19 MINIMUM DATA SET:

A. A long term care facility participating in the medicare and the MAD program is required to conduct a comprehensive, accurate, standardized, reproducible assessment of each eligible recipient resident's functional capacity. See Sections 4201 (a)(3) and 4211 (a)(3) of the Omnibus Reconciliation Act (OBRA) of 1987.

B. The capacity assessment

describes the resident's ability to perform daily life functions and any significant impairments in functional capacity. The assessment is based on a uniform minimum data set (MDS) of core elements and common definitions specified by the secretary of the federal health and human services department. A NF is required to use the most current iteration of the MDS. A section of the MDS requires a NF to identify eligible recipient residents who may be interested in transitioning back to his or her community.

(1) The resident assessment instrument (RAI) is specified by the state. State RAIs include at least the health care financing administration MDS, triggers, resident assessment protocols (RAPs) and utilization guidelines.

(2) On a date to be specified by the federal government, NFs will be required to encode the MDS in machine-readable form. After that date, all MDS reporting will be done electronically.

[8.312.2.19 NMAC - Rp, 8.312.2.19 NMAC, 10/1/12]

8.312.2.20 MEDICAL CARE CREDITS: If an eligible recipient resident has income beyond the maintenance allowance, MAD reimburses the NF for the difference between the NF's reimbursable rate and the medical care credit. The NF is responsible for collecting the amount reported as the medical care credit. These medical care credit requirements also apply to co-payments and deductibles for medicare crossover payments.

[8.312.2.20 NMAC - Rp, 8.312.2.20 NMAC, 10/15/12]

8.312.2.21 NURSE AIDE TRAINING: A NF must comply with nurse aide training requirements as a condition of MAD participation. See 42 CFR Section 483 Subpart D. The NF will not be approved if the NF has been out of compliance with federal requirement within the previous two calendar years.

A. **Requirements for nurse aide training:** A NF cannot employ individuals as nurse aides for more than four months unless they have completed a nurse aide training and competency evaluation program (NATCEP). The NATCEP program must have a minimum duration of 75 hours.

(1) A nurse aide who has not performed nursing or nursing-related services for monetary compensation for a period of 24 consecutive months since completion of a NATCEP must take either a new NATCEP or a new competency evaluation program (CEP).

(2) A NF must not use temporary nurse aides who have not completed a NATCEP or a CEP.

(3) A NF must ensure that students in the NATCEP programs do not perform any services for which they have not been trained and found proficient by instructors. A NF must ensure that all students in NATCEP programs are under the general supervision of licensed or registered nurses when they perform services for MAD eligible recipient residents.

(4) A NF must furnish regular performance reviews and in-service education to ensure that individuals who serve as nurse aides are competent to perform nurse aide services.

B. **Other nurse aide requirements:** A NF must not employ individuals who have been convicted by the court of abuse or neglect of any NF residents or misappropriation of any NF residents' property.

C. **Nurse aide registry:** DOH maintains a registry of all nursing aides who have successfully completed, who have been considered to have completed a NATCEP or CEP program or who have had the NATCEP or CEP requirement waived by the state.

[8.312.2.21 NMAC - Rp, 8.312.2.21 NMAC, 10/15/12]

8.312.2.22 PATIENT SELF DETERMINATION ACT: All adult eligible recipient residents of nursing facilities must be informed of their right to make their own health decisions, including the right to accept or refuse medical treatment as specified in the Patient Self-Determination Act. See 8.302.1 NMAC, *General Provider Policies*.

[8.312.2.22 NMAC - Rp, 8.312.2.22 NMAC, 10/15/12]

8.312.2.23 RESIDENT RIGHTS TO REQUEST AN ADMINISTRATIVE HEARING: A MAD eligible recipient resident who believes that the NF has erroneously determined that he or she should be transferred or discharged can request a HSD administrative hearing. A NF must provide an eligible recipient resident notice of the proposed transfer or discharge. The notice must inform the eligible recipient resident of his or her right to request a hearing, the method by which a hearing can be requested and his or her right to present evidence in person or through his or her representatives. See 8.352.2 NMAC, *Recipient Hearings*.

[8.312.2.23 NMAC - Rp, 8.312.2.23 NMAC, 10/15/12]

8.312.2.24 PRIOR APPROVAL AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services.

A. **Prior approval:** Certain procedures or services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process. See Subsection A of 8.311.2.16 NMAC, *emergency room services*.

B. **Eligibility determination:** Prior authorization of services does not guarantee that an individual is eligible for medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. **Reconsideration:** A provider who disagrees with a prior approval request denial or other review decisions can request a reconsideration of utilization review. See 8.350.2 *Reconsideration of Utilization Review Decisions.*

[8.312.2.24 NMAC - Rp, 8.312.2.24 NMAC, 10/15/12]

8.312.2.25 REIMBURSEMENT: Nursing facility providers must submit claims for reimbursement on the long term care turn around document (TAD) or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services.*

A. MAD reimburses a NF at the lesser of the following:

(1) the NF's billed charges;

(2) the prospective reimbursement rates constrained by the ceilings established by MAD; see 8.312.3 NMAC, *Cost Related Reimbursement of Nursing Facilities*; and

(3) the NF's billed charge must be their usual and customary charge for services; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

B. **Reimbursement limitations:** Payments are made only to a NF which meets the conditions for participation, specified in this section. Payments to a NF are limited to those service costs which are included as allowable costs under approved provisions of the state plan. See 8.312.3

NMAC, *Cost Related Reimbursement of Nursing Facilities*. All claims for payment from MAD are subject to utilization review and control.

C. **Reimbursement methodology:** See 8.312.3 NMAC, *Cost Related Reimbursement of Nursing Facilities.*

[8.312.2.25 NMAC - Rp, 8.312.2.25 NMAC, 10/15/12]

HISTORY OF 8.312.2 NMAC:

Pre- NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 310.0300, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 2/27/80.

MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 12/1/87.

MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 1/6/88.

MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/92.

SP-004.1903, Section 4, General Program Administration Reserve Beds, filed 6/10/81.

SP-004.1101, Section 4, General Program Administration Standards for Institutions, filed 6/26/81.

History of Repealed Material:

MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/92 - Repealed effective 2/1/95.

8.312.2 NMAC, Nursing Facilities, filed 5-27-2010 - Repealed effective 10-15-2012

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES

CHAPTER 314 LONG TERM CARE SERVICES-WAIVERS

PART 5 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.5.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

[8.314.5.1 NMAC - Rp, 8.314.5.1 NMAC, 11-1-12]

8.314.5.2 SCOPE: The rule applies to the general public.

[8.314.5.2 NMAC - Rp, 8.314.5.2 NMAC, 11-1-12]

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

[8.314.5.3 NMAC - Rp, 8.314.5.3 NMAC, 11-1-12]

8.314.5.4 DURATION: Permanent.

[8.314.5.4 NMAC - Rp, 8.314.5.4 NMAC, 11-1-12

8.314.5.5 EFFECTIVE DATE: November 1, 2012, unless a later date is cited at the end of a section.

[8.314.5.5 NMAC - Rp, 8.314.5.5 NMAC, 11-1-12]

8.314.5.6 OBJECTIVE: The objective of this rule is to govern the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.

[8.314.5.6 NMAC - Rp, 8.314.5.6 NMAC, 11-1-12]

8.314.5.7 DEFINITIONS:

A. **Activities of daily living (ADLs):** Those activities associated with a person's daily functioning.

B. **Individual service plan (ISP):** A treatment plan for an eligible recipient that includes the eligible recipient's needs, functional level, intermediate and long range goals, statement for achieving the goals and specifies responsibilities for the care needs. The plan determines the services allocated to the eligible recipient within program allowances.

C. **Supports intensity scale (SIS):** A standardized assessment tool that provides a reliable framework to quantify the support needs of individuals with developmental disabilities.

D. **Waiver:** Permission from the centers for medicaid and medicare services (CMS) to cover a particular population or service not ordinarily allowed.

[8.314.5.7 NMAC - N, 11-1-12]

8.314.5.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.314.5.8 NMAC - Rp, 8.314.5.8 NMAC, 11-1-12]

8.314.5.9 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER: To help New Mexicans who have a developmental disability, intellectual disability (ID) or a specified related condition to receive services in a cost-effective manner, the New Mexico medical assistance division (MAD) has obtained a waiver of certain federal regulations to provide home and community-based services waiver (HCBSW) programs to eligible recipients as an alternative to institutionalization.

[8.314.5.9 NMAC - Rp, 8.314.5.9 NMAC, 11-1-12]

8.314.5.10 ELIGIBLE PROVIDERS:

A. Health care to New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. Eligible providers must be approved by the department of health/ developmental disabilities support division (DOH/DDSD) or its designee and have an approved MAD provider participation agreement (PPA) as a DDW provider.

C. MAD through its designee, DOH/DDSD, follows a subcontractor model for certain DDW services. A provider agency, following the DOH/DDSD model, must ensure the subcontractors or employees meet all required qualifications. Provider agencies must provide oversight of subcontractors

and employees to ensure subcontractors or employees meet all required MAD and DOH/DDSD qualifications. There must be oversight of subcontractors and employees by the provider agency to ensure the services are delivered in accordance with the all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW services standards and the MAD rules. Pursuant to federal regulations, an agency may not employ or subcontract with the spouse or the parent of a minor child receiving services to provide direct care services for the their spouse or minor child.

D. **Qualifications of case management agency providers:** Case management providers must comply with all accreditation policies and requirements set forth by the DOH/DDSD, DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Case management providers must ensure that all case managers, whether subcontractors or employees, meet all qualifications set forth by DOH/DDSD and its DDW service standards and the MAD rules. Case management providers must ensure that case managers meet the following qualifications:

(1) one year clinical experience, related to the target population; and

(2) one of the following:

(a) social worker licensure as defined by the NM board of social work examiners; or

(b) registered nurse licensure as defined by the NM board of nursing; or

(c) bachelor's or master's degree in social work, psychology, counseling, nursing, special education, or closely related field;

(3) training requirements as specified by DDSD/DOH; and

(4) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

E. **Qualifications of respite provider agencies:** Respite provider agencies must comply with DOH/DDSD accreditation policy and all requirements set forth by the DOH/DDSD service definition, all requirements outlined in the DDW service standards, and the MAD rules. Respite provider agencies must ensure that all direct support personnel, whether subcontractors or employees, meet all qualifications set forth by DOH/DDSD and in its DDW service standards and the MAD. Respite provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH/DDSD;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

F. **Qualifications of adult nursing provider agencies:** Adult nursing provider agencies must comply with all requirements set forth by DOH/DDSD, DDW service standards and all applicable state and federal laws and all medicaid rules. Adult nursing provider agencies must ensure that all nurses, whether subcontractors or employees, meet all qualifications set forth by the DOH/DDSD, and its DDW service standards and MAD rules. Adult nursing provider agencies must ensure that all nurses, whether subcontractors or employees meet all qualifications set forth by the DOH/DSD service definition, all requirements outlined in the DDW service standards and the MAD rules. Direct nursing services are provided by registered or practical nurses licensed by the New Mexico state board of nursing. Nurses must have a minimum of one year of supervised nursing experience, in accordance with the New Mexico Nursing Practice Act and must comply with all aspects of the New Mexico Nursing Practice Act, including requirements regarding delegation of specific nursing functions.

G. **Qualifications of therapy provider agencies:** Therapy provider agencies must comply with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Therapy provider agencies must ensure that all therapists including physical, occupational, and speech therapists, physical therapy assistants (PTAs) and certified occupational therapy assistants (COTAs) whether subcontractors or employees, meet all qualifications set forth by DOH/DDSD and the MAD rules and DDW service standards including relevant licensure or certification in their respective discipline from the New Mexico regulation and licensing department.

H. **Qualifications for community living supports provider agencies:** Living supports consist of family living and supported living. Living supports provider agencies must comply with accreditation policy and all requirements set forth by the DOH/DDSD, DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Living supports provider agencies must ensure that all direct support personnel meet all qualifications set forth by DOH/DDSD and its DDW service standards and MAD rules. Living supports provider agencies and direct support personnel must: (a) comply with all training requirements as specified by DOH/DDSD; (b) have and maintain documentation of current CPR and first aid certification; and (c) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

(1) Family living provider agencies must ensure that all direct support personnel, whether subcontractors or employees, meet all qualifications set forth by DOH/DDSD and its DDW service standards and the MAD rules. The direct support personnel employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency.

(2) Supported living provider agencies must ensure that all direct support personnel meet all qualifications set forth by DOH/DDSD and the MAD rules and its DDW service standards. Supported living provider agencies must employ or subcontract with at least one licensed registered nurse and comply with the New Mexico Nurse Practicing Act.

I. **Qualifications of customized community supports provider agencies:** Customized community supports provider agencies must comply with accreditation policy and all requirements set forth by the DOH/DDSD, DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Customized community supports providers must comply with all provisions of the performance based measure requirements. Customized community supports provider agencies must ensure that all direct support personnel meet all qualifications set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Customized community supports provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH/DDSD;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

J. **Qualifications of community integrated employment provider agencies:** Community integrated employment provider agencies must comply with the DOH/DDSD accreditation policy and all requirements set forth by the DOH/DDSD DDW service definition, all requirements outlined in the DDW services standards and the MAD rules. Community integrated employment provider agencies must comply with all provisions of the performance based measure requirements. Community integrated employment provider agencies must ensure that all direct support

personnel meet all qualifications set forth by DOH/DDSD and the DDW service standards and MAD rules. Community integrated employment provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH/DDSD;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

K. **Qualifications of behavioral support consultation provider agencies:** Behavioral support consultation provider agencies must comply with all requirements set forth by the DOH/DDSD, DDW service standards and MAD rules. Behavioral support consultation provider agencies must ensure that all behavioral support consultants, whether subcontractors or employees, meet all qualifications set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(1) Providers of behavioral support consultation services must be currently licensed in one of the following professions and maintain that licensure by the NM appropriate board or licensing authority:

(a) a licensed mental health counselor (LMHC), or

(b) a licensed psychiatrist; or

(c) a licensed clinical psychologist; or

(d) a licensed psychologist associate, (masters or Ph.D. level); or

(e) a licensed independent social worker (LISW); or

(f) a licensed master social worker (LMSW); or

(g) a licensed professional clinical counselor (LPCC); or

(h) a licensed professional counselor (LPC); or

(i) a licensed psychiatric nurse (MSN/RNCS); or

(j) a licensed marriage and family therapist (LMFT); or

(k) a licensed practicing art therapist (LPAT); or

(l) other related licenses and qualifications may be considered with DOH/DDSD prior written approval.

(2) Providers of behavioral support consultation must have a minimum of one year of experience working with persons with developmental disabilities.

(3) Behavioral support consultation providers must receive training in accordance with DDSD training policy.

L. **Qualifications of nutritional counseling provider agencies:** Nutritional counseling provider agencies must comply with all requirements set forth by DOH/DDSD DDW service definitions, all requirements outlined in the DDW service standards and MAD rules. Nutritional counseling provider agencies must ensure that all nutritional counseling providers, whether subcontractors or employees, meet all qualifications set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Nutritional counseling providers must be registered as dietitians by the commission on dietetic registration of the American dietetic association and licensed in New Mexico as a nutrition counselor.

M. **Qualifications of environmental modification provider agencies:** Environmental modification contractors must be bonded, licensed by the state of New Mexico and authorized to complete the specified project. Environmental modification provider agencies must comply with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Environmental modification provider agencies must meet all qualifications set forth by the DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. All services shall be provided in accordance with applicable federal, state and local building codes.

N. **Qualifications of crisis supports provider agencies:** Crisis supports provider agencies must comply with all requirements set forth by the DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Crisis supports provider agencies must ensure that direct support personnel, whether subcontractors or employees, meet all qualifications set forth by the DOH/DDSD and the DDW service standards. Crisis supports provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH/DDSD;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

O. **Qualifications for non-medical transportation provider agencies:** Non-medical transportation provider agencies must comply with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Non-medical transportation provider agencies must ensure that all transportation provider agencies meet all qualifications set forth by DOH/DDSD DDW definition, all requirements outlined in the DDW service standards and MAD rules. Non-medical transportation provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH/DDSD;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

P. **Qualifications of supplemental dental care provider agencies:** Supplemental dental care provider agencies must comply with all requirements set forth by the DOH/DDSD, DDW service standards and all applicable state and federal laws. Supplemental dental care providers must contract with New Mexico licensed dentists and dental hygienists who are licensed as per New Mexico regulation and licensing department, 61-5A-1 et seq., NMSA 1978. The supplemental dental care provider will ensure that a licensed dentist per New Mexico regulation and licensing provides the oral examination; ensure that a dental hygienist certified by the New Mexico board of dental health care provides the routine dental cleaning services; demonstrate fiscal solvency; and will function as a payee for the service.

Q. **Qualifications of assistive technology purchasing agent providers and agencies:** Assistive technology purchasing agent providers and agencies must comply with all requirements set forth by the DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

R. **Qualifications of independent living transition service provider agencies:** Independent living transition service provider agencies must comply with all requirements and must meet all qualifications set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

S. **Qualifications of personal support technology/on-site response service provider agencies:** Personal support technology/on-site response service provider agencies must comply and must meet all qualifications with all requirements set forth by DOH/DDSD DDW service definition and all requirements outlined in the DDW service standards and the MAD rules. Personal support technology/on-site response service provider agencies must comply with all laws, rules, and regulations from the federal communications commission (FCC) for telecommunications.

T. **Qualifications of preliminary risk screening and consultation related to inappropriate sexual behavior provider agencies:** Preliminary risk screening and consultation related to inappropriate sexual behavior provider agencies must comply with all requirements set forth by the DOH/DDSD, DDW service standards and all applicable state and federal laws. Preliminary risk screening and consultation related to inappropriate sexual behavior provider agencies must meet all qualifications set forth by the DOH/DDSD and the DDW service standards. Preliminary risk screening and consultation related to inappropriate sexual behavior provider agencies must have a current independent practice license through a board of the New Mexico regulation and licensing department in a counseling or counseling-related field (e.g., counseling and therapy practice, psychologist examiners, social work examiners), and a master's or doctoral degree in a counseling or counseling-related field from an accredited college or university. Preliminary risk screening and consultation related to inappropriate sexual behavior provider agencies must comply with all training requirements as specified by DOH/DDSD.

U. **Qualifications of socialization and sexuality education provider agencies:** Socialization and sexuality education provider agencies must comply with all requirements set forth by the DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Socialization and sexuality education provider agencies must meet all qualifications set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Socialization and sexuality education provider agencies must have one of the following providers rendering the service:

(1) a master's degree or higher in psychology;

(2) a master's degree or higher in counseling;

(3) a master's degree or higher in special education;

(4) a master's degree or higher in social work;

(5) a master's degree or higher in a related field;

(6) a New Mexico registered nurse or as a licensed practical nurse;

(7) a bachelor's degree in special education;

(8) hold a certification in special education; and

(9) been approved by the DDS office of behavioral services as a socialization and sexuality education provider; and

(10) must meet training requirements as specified by DDSD.

V. **Qualifications of customized in-home supports provider agencies:** The customized in-home supports provider agencies must comply with DOH/DDSD accreditation policy and all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Customized in-home supports provider agencies must ensure that all direct support personnel, whether subcontractors or employees, meet all qualifications set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Customized in-home supports provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH/DDSD;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

W. **Qualifications of intense medical living supports provider agencies:** Intense medical living supports provider agencies must comply with the accreditation policy and all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Intense medical living supports provider agencies must employ or subcontract with at least one licensed registered nurse by the New Mexico state board of Nursing. Nurses must have a minimum of one year of supervised nursing experience, in accordance with the New Mexico Nursing Practice Act. Intense medical living supports provider agencies must ensure that all direct support personnel meet all qualifications set forth by the DOH/DDSD, DDW service standards and MAD rules. Intense medical living supports provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH/DDSD; and

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

[8.314.5.10 NMAC - Rp, 8.314.5.10 NMAC, 11-1-12]

8.314.5.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care programs eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services. See 8.302.1 NMAC, *General Provider Policies*.

[8.314.5.11 NMAC - Rp, 8.314.5.11 NMAC, 11-1-12]

8.314.5.12 ELIGIBLE RECIPIENTS: DD waiver services are intended for individuals who have developmental disabilities limited to intellectual disability (ID) or a specific related condition. Eligibility criteria is located at Subsection B of 8.290.400.10 NMAC

[8.314.5.12 NMAC - Rp, 8.314.5.12 NMAC, 11-1-12]

8.314.5.13 COVERED WAIVER SERVICES: The program is limited to the number of federally authorized unduplicated recipient (UDR) positions and program funding. All covered services in an individual service plan (ISP) must be authorized and cannot exceed the allowable amount associated with the assigned service package. Covered services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. MAD covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an ICF-IID.

A. Assessment: DOH/

DDSD utilizes the supports intensity scale (SIS) as its standardized assessment tool that is conducted for all recipients transitioning into the new waiver, new allocations into the waiver, and at least ever three years thereafter. The SIS assessment is applied to eligible recipients that are 18 years of age or older. The SIS provides a reliable framework to quantify the support needs of an eligible recipient with developmental disabilities. The SIS assessment obtains information about the needs of each eligible recipient, which may include an exceptional behavioral needs assessment and medical support needs assessment, as appropriate. A standardized algorithm (calculation) for home and community-based waivers is applied to the SIS score to determine the NM SIS group. The results of the NM SIS group may be reviewed by a DOH verification team for quality assurance purposes.

(1) There are seven NM SIS groups, each has a benefit service package known as the service package. The service package consists of a base budget a professional service budget, other services budget that make up the total funding authorized in the eligible recipient's ISP. Services included in the service package for each NM SIS group are specified in the DDW service standards. The service package for each NM SIS group allows an eligible recipient flexibility to choose services to meet his/her needs within the maximum amount allowed in the service package assigned to the corresponding NM SIS group.

(2) An eligible recipient may request a subsequent SIS assessment (prior to three year schedule) based on a change of circumstances or condition that results in a significant change to the amount of supports and services needed to maintain the health and safety of the eligible recipient. A subsequent SIS will not be conducted unless approved by DOH/DDSD.

(3) Administration of the SIS assessments shall be reviewed by DOH/DDSD for the purpose of quality assurance.

B. Services available in service packages:

(1) **Case management services:** Case management services assist eligible recipients to access medicaid waiver services and medicaid state plan services. Case managers also link the eligible recipient to needed medical, social, educational and other services, regardless of funding source. Waiver services are intended to enhance, not replace existing natural supports and other available community resources. Services will emphasize and promote the use of natural and generic supports to address the eligible recipient's assessed needs in addition to paid supports. Case managers facilitate and assist in assessment activities, as appropriate. Case management services are person-centered and intended to support eligible recipients in pursuing his or her desired life outcomes while gaining independence, and access to services and supports. Case management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the eligible recipient, his or her designated representative/guardian, and the entire interdisciplinary team. The case manager is an advocate for the eligible recipient they serve, is responsible for developing the individualized service plan (ISP) and for ongoing monitoring of the provision of services included in the ISP. Case management services include but are not limited to activities such as: assessing needs; facilitating eligibility determination for persons with developmental disabilities; directing the service planning process; advocating on behalf of the eligible recipient; coordinating service delivery; assuring services are delivered as described in the individualized service plan (ISP); and maintaining a complete current central eligible recipient record (e.g. ISP, ISP budget, level of care documentation, assessments).

(a) Cost-effectiveness is a waiver program requirement mandated by federal policy; the fiscal responsibilities of the case manager include assuring cost containment by preventing the expense of waiver services from exceeding a maximum cost established by DOH and by exploring other options to address expressed needs.

(b) Case managers must evaluate and monitor direct service through face-to-face visits with the eligible recipient to ensure the health and welfare of the eligible recipient, and to monitor the implementation of the ISP.

(c) Case management services must be provided in accordance with the accreditation policy and with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and MAD rules.

(2) **Respite services:** Respite is a flexible family support service. The primary purpose of respite is to provide support to the eligible recipient and give the primary, unpaid caregiver relief and time away from their duties. Respite services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills and providing opportunities for play and other recreational activities; community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make his/her own choices with regard to daily activities. Respite will be scheduled as determined by the primary caregiver. An eligible recipient receiving living supports and customized in-home supports (not living with a family member), may not access respite. Respite may be provided in the eligible recipient's own home, in a provider's home or in a community setting of the family's choice. Respite services must be provided in accordance with the accreditation policy and all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(3) **Adult nursing services:** Adult nursing services are provided by licensed registered nurses or licensed practical nurses to an eligible adult recipient. Adult nursing services are intended to support the highest practicable level of health, functioning and independence for a DDW eligible recipient age 21 and older with a variety of health conditions, except for an eligible recipient receiving nursing supports through supported living and intensive medical living services, where such nursing supports are included as part of the living service and addressed within those respective services standards. Any adult nursing service provided during the hours of customized community supports cannot be billed as a separate rate because nursing is included in the customized community supports rate. There are two categories of adult nursing services: (a) assessment and consultation services which include a comprehensive health assessment and basic nurse consultation of and with an eligible recipient; and (b) ongoing services, which require prior authorization and are tied to the eligible recipient's specific health needs revealed in the comprehensive health assessment.

(a) Adult nursing services support the delivery of professional nursing services in compliance with the New Mexico Nurse Practice Act and in accordance with professional standards of practice.

(b) Eligible children and youth recipients receive medically necessary nursing services through the medicaid state plan early periodic screening, diagnostic and treatment (EPSDT) program and are, therefore, not eligible for this service through the waiver.

(c) Adult nursing services for eligible recipients must be provided in accordance with the accreditation policy and all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(4) **Therapy services:** Therapy services are to be delivered consistent with the participatory approach philosophy and two models of therapy services (collaborative-consultative and direct treatment). These models support and emphasize increased participation, independence and community inclusion in combination with health and safety. Therapy services are designed

to support achievement of ISP outcomes and prioritized areas of need identified through therapeutic assessment. Physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) are skilled therapies that are recommended by an eligible recipient's interdisciplinary team (IDT) members and a clinical assessment that demonstrates the need for therapy services. Therapy services for eligible adult recipients require a prior authorization except for an initial assessment. A licensed practitioner, as specified by applicable state laws and standards, provides the skilled therapy services. Therapy services for eligible adult recipients must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. For therapy services, eligible children and youth recipients receive medically necessary nursing services through the medicaid state plan EPSDT benefits.

(a) **Physical therapy:** Physical therapy is a skilled licensed therapy service involving the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance, and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy prevents the onset, symptoms and progression of impairments, functional limitations, and disability that may result from diseases, disorders, conditions or injuries. Licensed physical therapy assistant (PTA) may perform physical therapy procedures and related tasks pursuant to a plan of care/therapy intervention plan written by the supervising physical therapist

(b) **Occupational therapy:** Occupational therapy is a skilled, licensed therapy service involving the use of everyday life activities (occupations) for the purpose of evaluation, treatment, and management of functional limitations. Occupational therapy addresses physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being and quality of life. Certified occupational therapy assistants (COTAs) may perform occupational therapy procedures and related tasks pursuant to a therapy intervention plan written by the supervising occupational therapist (OT) and in accordance with the current NM Occupational Therapy Act. Occupational therapy services typically include:

(i) evaluation and customized treatment programs to improve the eligible recipient's ability to engage in daily activities;

(ii) evaluation and treatment for enhancement of performance skills;

(iii) health and wellness promotion;

(iv) environmental access and assistive technology evaluation and treatment; and

(v) training/consultation to eligible recipient's family members and direct support personnel.

(c) **Speech-language pathology:** Speech-language pathology service, also known as speech therapy, is a skilled therapy service, provided by a speech-language pathologist that involves the non-medical application of principles, methods and procedures for the diagnosis, counseling, and instruction related to the development of and disorders of communication including speech, fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction and sensory-motor competencies. Speech-language pathology services are also used when an eligible recipient requires the use of an augmentative communication device. For example, speech-language pathology services are intended to:

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

(ii) treat a specific condition clinically related to an intellectual developmental disability; or

(iii) improve or maintain the eligible recipient's ability to safely eat foods, drink liquids or manage oral secretions while minimizing the risk of aspiration or other potential injuries or illness related to swallowing disorders.

(5) **Living supports:** Living supports are residential habilitation services that are individually tailored to assist an eligible recipient 18 years or older who is assessed to need daily support or supervision with the acquisition, retention, or improvement of skills related to living in the community to prevent institutionalization. Living supports include residential instruction intended to increase and promote independence and to support an eligible recipient to live as independently as possible in the community in a setting of his or her own choice. Living support services assist and encourage an eligible recipient to grow and develop, to gain autonomy, become self-governing and pursue their own interests and goals. Living support providers take positive steps to protect and promote the dignity, privacy, legal rights, autonomy and individuality of each eligible recipient who receives services. Services promote inclusion in the community and eligible recipients are afforded the opportunity to be involved in the community and actively participate using the same resources and doing the same activities as other community members. Living supports will assist an eligible recipient to access generic and natural supports and opportunities to establish or maintain meaningful relationships throughout the community. Living supports providers are responsible for providing an appropriate level of services and supports up to 24 hours per day, seven days per week. Room and board costs are reimbursed through the eligible recipient's SSI or other personal accounts and cannot be paid through the medicaid waiver. Living supports services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Living supports consists of family living and supported living as follows:

(a) **Family living:** Family living is intended for an eligible recipient who is assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family living is a residential habilitation service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on his or her own in a non-residential setting. Family living services are designed to address assessed needs and identified individual eligible recipient outcomes. Family living is direct support and assistance to no more than two eligible recipients furnished by a natural or host family member, or companion who meets the requirements and is approved to provide family living services in the eligible recipient's home or the home of the family living direct care personnel. The eligible recipient lives with the paid direct support personnel. The provider agency is responsible for substitute coverage for the primary direct support personnel to receive sick leave and time off as needed. Home studies: The family living services provider agency shall complete all DOH/DDSD requirements for approval of each direct support personnel, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the provider agency to conduct home studies shall be approved by DDSD. Family living services: Family living can be provided to no more than two eligible recipients with developmental disabilities at a time. An exception may be granted by DOH/DDSD if three eligible recipients are in the residence, but only two of the three are on the waiver and the arrangement is approved by DOH/DDSD based on the home study documenting the ability of the

family living services provider agency to serve more than two eligible recipients in the residence; or there is documentation that identifies the eligible recipients as siblings or there is documentation of the longevity of a relationship (e.g., copies of birth certificates or social history summary); documentation shall include a statement of justification from a social worker, psychologist, and any other pertinent professionals working with the eligible recipients. Family living services cannot be provided in conjunction with any other living supports service, respite, or nutritional counseling.

(b) **Supported living:** Supported living is intended for an eligible recipient who is assessed to need residential habilitation to ensure health and safety. Supported living is a residential habilitation service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on his or her own in a non-residential setting. Supported living services are designed to address assessed needs and identified individual eligible recipient outcomes. The service is provided to two to four eligible recipients in a community residence. Prior authorization is required from DOH/DDSD for an eligible recipient to receive this service when living alone. When DOH/DDSD approves an eligible recipient utilizing the supports intensity scale (SIS) group G, the supported living providers will ensure that agency's direct support personnel receive individualized, eligible recipient specific behavior training and access ongoing behavior support from the behavior support consultant. The provider agency will provide the necessary levels of staffing for the eligible recipient during times of increased risk of harm to self or others. The support will return to a typical staffing pattern once the circumstance associated with the increased risk has ended. Supported living services cannot be provided in conjunction with any other living supports service, respite, or nutritional counseling.

(6) **Customized community supports:** Customized community supports consist of individualized services and supports that enable an eligible recipient to acquire, maintain, and improve opportunities for independence, community integration and employment. Customized community supports services are designed around the preferences and choices of each eligible recipient and offer skill training and supports to include: adaptive skill development; adult educational supports; citizenship skills; communication; social skills, socially appropriate behaviors; self advocacy, informed choice; community integration and relationship building. This service provides the necessary support to develop social networks with community organizations to increase the eligible recipient's opportunity to expand valued social relationships and build connections within local communities. This service helps to promote self-determination, increases independence and enhances the eligible recipient's ability to interact with and contribute to his or her community.

(a) Customized community supports services will include based on assessed need, personal support, nursing oversight, medication assistance/ administration, and integration of strategies in the therapy and healthcare plans into the eligible recipient's daily activities.

(b) The customized community supports provider will act as a fiscal management agency for the payment of adult education opportunities as determined necessary for the eligible recipient.

(c) Customized community supports services may be provided regularly or intermittently based on the needs of the eligible recipient and are provided during the day, evenings and weekends.

(d) Customized community supports may be provided in a variety of settings to include the community, classroom, and site-based locations. Services provided in any location are required to provide opportunities that lead to participation and integration in the community or support the eligible recipient to increase his/her growth and development.

(e) Pre-vocational and vocational services are not covered under customized community supports.

(f) Customized community supports services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(7) **Community integrated employment:** Community integrated employment provides supports that achieve employment in jobs of the eligible recipient's choice in his or her community to increase his or her economic independence, self-reliance, social connections and ability to grow within a career. Community integrated employment results in employment alongside non-disabled coworkers within the general workforce or in business ownership. This service may also include small group employment including mobile work crews or enclaves. An eligible recipient is supported to explore and seek opportunity for career advancement through growth in wages, hours, experience or movement from group to individual employment. Each of these activities is reflected in individual career plans. Community integrated employment services must not duplicate services covered under the Rehabilitation Act or the Individuals with Disabilities Education Act (IDEA). Compensation shall comply with state and federal laws including the Fair Labor Standards Act. Medicaid funds (e.g., the provider agency's reimbursement) may not be used to pay the eligible recipient for work. Community integrated employment services must be provided in accordance with the DOH/DDSD DDW service definitions and standards. Community integrated employment consists of job development, self-employment, individual community integrated employment and group community integrated employment models.

(a) **Self-employment:** The community integrated employment provider provides the necessary assistance to develop a business plan, conduct a market analysis of the product or service and establish necessary infrastructure to support a successful business. Self-employment does not preclude employment in the other models. Self-employment may include but is not limited to the following: complete a market analysis of product/business viability; creation of a business plan including development of a business infrastructure to sustain the business over time, including marketing plans; referral to and coordination with the division of vocational rehabilitation (DVR) for possible funds for business start up; assist in obtaining required licenses necessary tax IDs, incorporation documents and completing any other business paperwork required by local and state codes; support the eligible recipient to develop and implement a system for bookkeeping and records management.; provide effective job coaching and on-the-job training and skill development; and arrange transportation or public transportation during self-employment services.

(b) **Individual community integrated employment:** Job coaching for employed eligible recipients in integrated community based settings. The amount and type of individual support needed will be determined through vocational assessment including on-the-job analysis. Individual community integrated employment may include, but is not limited to the following: provide effective job coaching and on-the-job training as needed to assist the eligible recipient to maintain the job placement and enhance skill development; and arrange transportation or public transportation during individual community integrated employment services.

(c) **Group community integrated employment:** More than one eligible recipient works in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers or the public occurs. Group community integrated employment may include but is not limited to the following: participate with the interdisciplinary team (IDT) to develop a plan to assist an eligible recipient who desires to move from group employment

to individual employment; and provide effective job coaching and on-the-job training as needed to assist the eligible recipient to maintain the job placement and enhance skill development.

(8) **Behavioral support consultation services:** Behavioral support consultation services guide the IDT to enhance the eligible recipient's quality of life by providing positive behavioral supports for the development of functional and relational skills. Behavioral support consultation services also identify distracting, disruptive, or destructive behavior that could compromise quality of life and provide specific prevention and intervention strategies to manage and lessen the risks this behavior presents. Behavioral support consultation services do not include individual or group therapy, or any other behavioral services that would typically be provided through the behavioral health system.

(a) Behavioral support consultation services are intended to augment functional skills and positive behaviors that contribute to quality of life and reduce the impact of interfering behaviors that compromise quality of life. This service is provided by an authorized behavioral support consultant and includes an assessment and positive behavior support plan development; IDT training and technical assistance; and monitoring of an eligible recipient's behavioral support services.

(b) Behavioral support consultation services must be provided in accordance with the accreditation policy and all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(9) **Nutritional counseling services:** Nutritional counseling services include the assessment, evaluation, collaboration, planning, teaching, consultation and implementation and monitoring of a nutritional plan that supports the eligible recipient to attain or maintain the highest practicable level of health. Nutritional counseling services are in addition to those nutritional or dietary services allowed in the eligible recipient's medicaid state plan benefit, or other funding source. This service does not include oral-motor skill development services, such as those services provided by a speech pathologist. Because nutritional counseling is included in the reimbursement rate for living supports, nutritional counseling cannot be billed as a separate service during the hours of living supports. Nutritional counseling services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

(10) **Environmental modification services:** Environmental modifications services include the purchase and installation of equipment or making physical adaptations to an eligible recipient's residence that are necessary to ensure the health, welfare and safety of the individual or enhance the eligible recipient's access to the home environment and increase the eligible recipient's ability to act independently.

(a) Adaptations, instillations and modifications include:

(i) heating and cooling adaptations;

(ii) fire safety adaptations;

(iii) turnaround space adaptations;

(iv) specialized accessibility, safety adaptations or additions;

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

(vi) installation of trapeze and mobility tracks for home ceilings;

(vii) installation of ramps and grab-bars;

(viii) widening of doorways or hallways;

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

(x) purchase or installation of air filtering devices;

(xi) purchase or installation of lifts or elevators;

(xii) purchase and installation of glass substitute for windows and doors; purchase and installation of modified switches, outlets or environmental controls for home devices; and

(xiii) purchase and installation of alarm and alert systems or signaling devices.

(b) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

(c) Environmental modification services must be provided in accordance with applicable federal, state and local building codes.

(d) Environmental modification services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(11) **Crisis supports:** Crisis supports are services that provide intensive supports by appropriately trained staff to an eligible recipient experiencing a behavioral or medical crisis either within the eligible recipient's present residence or in an alternate residential setting. Crisis support must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

(a) **Crisis supports in the eligible recipient's residence:** These services provide crisis response staff to assist in supporting and stabilizing the eligible recipient while also training and mentoring staff or family members, who normally support the eligible recipient, in order to remediate the crisis and minimize or prevent recurrence.

(b) **Crisis supports in an alternate residential setting:** These services arrange an alternative residential setting and provide crisis response staff to support the eligible recipient in that setting, to stabilize and prepare the eligible recipient to return home or to move into another permanent location. In addition, staff will arrange to train and mentor staff or family members who will support the eligible recipient long term once the crisis has stabilized, in order to minimize or prevent recurrence.
all requirements set forth by DOH/DDSD DDW service definition.

(c) Crisis support staff will deliver such support in a way that maintains the eligible recipient's normal routine to the maximum extent possible. This includes support during attendance at employment or customized community supports services, which may be billed on the same dates and times of service as crisis supports.

(d) This service requires prior written approval and referral from the office of behavioral services (OBS). Crisis supports are designed to be a short-term response (two to 90 calendar days).

(e) The timeline may exceed 90 calendar days under extraordinary circumstances, with approval from office of behavioral services (OBS), in which case duration and intensity of the crisis intervention will be assessed weekly by OBS staff.

(12) **Non-medical transportation:** Non-medical transportation services assists the eligible recipient in accessing other waiver supports and non-waiver activities identified in the individual service plan (ISP). Non-medical transportation enables eligible recipient to gain physical access to non-medical community services and resources promoting the eligible recipient opportunity and responsibility in carrying out ISP activities. This service is to be considered only when transportation is not available through the state medicaid state plan or when other arrangements cannot be made. Non-medical transportation includes

funding to purchase a pass for public transportation for the eligible recipient. Non-medical transportation provider services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition.

(13) **Supplemental dental care:** Supplemental dental care provides one routine oral examination and cleaning to eligible recipients on the waiver for the purpose of preserving or maintaining oral health. Supplemental dental care provided on the waiver is for eligible recipients that require routine cleaning more frequently than covered under the medicaid state plan. The supplemental dental care service must be provided in accordance with the DOH/DDSD DDW service definition, all requirements outlined in the DW service standards and the MAD rules.

(14) **Assistive technology purchasing agent service:** Assistive technology purchasing agent service is intended to increase the eligible recipient's physical and communicative participation in functional activities at home and in the community. Items purchased through the assistive technology service assist the eligible recipient to meet outcomes outlined in the ISP, increase functional participation in employment, community activities, activities of daily living, personal interactions, or leisure activities, or increase the eligible recipient's safety during participation of the functional activity.

(a) Assistive technology services allows an eligible recipient to purchase needed items to develop low-tech augmentative communication, environmental access, mobility systems and other functional assistive technology, not covered through the eligible recipient's medicaid state plan benefits.

(b) Assistive technology purchasing agent providers act as a fiscal agent to either directly purchase, or reimburse team members who purchase devices or materials which have been prior authorized by the DOH/DDSD on behalf of an eligible recipient.

(c) Assistive technology purchasing agent services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(15) **Independent living transition services:** Independent living transition services are one-time set-up expenses for an eligible recipient who transitions from a 24 hour living supports setting into a home or apartment of their own with intermittent support that allows his or her to live more independently in the community. The service covers expenses associated with security deposits that are required to obtain a lease on an apartment or home, set-up fees or deposits for utilities (telephone, electricity, heating, etc.), furnishings to establish safe and healthy living arrangements: bed, chair, dining table and chairs, eating utensils and food preparation items, and a telephone. The service also covers services necessary for the eligible recipient's health and safety such as initial or one-time fees associated with the cost of paying for pest control, allergen control or cleaning services prior to occupancy. Independent living transition services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(16) **Personal support technology/on-site response service:** Personal support technology/on-site response service is an electronic device or monitoring system that supports the eligible recipients to be independent in the community or in their place of residence with limited assistance or supervision of paid staff. This service provides 24-hour response capability or prompting through the use of electronic notification and monitoring technologies to ensure the health and safety of the eligible recipient in services. Personal support technology/on-site response service is available to eligible recipients who have a demonstrated need for timely response due to health or safety concerns. Personal support technology/on-site response service includes the installation of the rented electronic device, monthly maintenance fee for the electronic device, and hourly response funding for staff that support the eligible recipient when the device is activated. Personal support technology/on-site response services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

(17) **Preliminary risk screening and consultation related to inappropriate sexual behavior:** Preliminary risk screening and consultation related to inappropriate sexual behavior (PRSC) identifies, screens, and provides periodic technical assistance and crisis intervention when needed to the IDTs supporting eligible recipients with risk factors for sexually inappropriate or offending behavior, as defined in the DDW standards. This service is part of a continuum of behavior support services (including behavior support consultation and socialization and sexuality services) that promote community safety and reduce the impact of interfering behaviors that compromise quality of life.

(a) The key functions of preliminary risk screening and consultation related to inappropriate sexual behavior services are:

(i) provide a structured screening of behaviors that may be sexually inappropriate;

(ii) develop and document recommendations in the form of a report or consultation notes;

(iii) development and periodic revisions of risk management plans, when recommended; and

(iv) consultation regarding the management and reduction of sexually inappropriate behavioral incidents that may pose a health and safety risk to the eligible recipient or others.

(b) Preliminary risk screening and consultation related to inappropriate sexual behavior services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(18) **Socialization and sexuality education service:** Socialization and sexuality education service is carried out through a series of classes intended to provide a proactive educational program about the values and critical thinking skills needed to form and maintain meaningful relationships, and about healthy sexuality and sexual expression. Social skills learning objectives include positive self-image, communication skills, doing things independently and with others, and using paid and natural supports. Sexuality learning objectives include reproductive anatomy, conception and fetal development, safe sex and health awareness. Positive outcomes for the eligible recipient include safety from negative consequences of being sexual, assertiveness about setting boundaries and reporting violations, expressing physical affection in a manner that is appropriate and making informed choices about the relationships in his/her life. Independent living skills are enhanced and improved work outcomes result from better understanding of interpersonal boundaries, and improved communication, critical thinking and self-reliance skills. Socialization and sexuality education services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(19) **Customized in-home supports:** Customized in-home support services is not a residential habilitation service and is intended for an eligible recipient that does not require the level of support provided under living supports services. Customized in-home supports provide an eligible recipient the opportunity to design and manage the supports needed to live in their own home or their family home. Customized in-home supports includes a combination of instruction and personal support activities provided intermittently as he or she would normally occur to assist the eligible recipient with ADLs, meal

preparation, household services, and money management. The services and supports are individually designed to instruct or enhance home living skills, community skills and to address health and safety as needed. This service provides assistance with the acquisition, improvement or retention of skills that provides the necessary support to achieve personal outcomes that enhance the eligible recipient's ability to live independently in the community. Customized in-home support services must be provided in accordance with policy and all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(20) **Intense medical living supports:** Intense medical living supports agencies provide community living supports for an eligible recipient who requires daily direct skilled nursing, in conjunction with community living supports that promote health and assist the eligible recipient to acquire, retain or improve skills necessary to live in the community and prevent institutionalization, consistent with each eligible recipient's ISP. An eligible recipients must meet criteria for intense medical living supports according to eligibility parameters in the standards for this service and require nursing care, ongoing assessment, clinical oversight and health management that must be provided directly by a registered nurse or a licensed practical nurse in accordance with the New Mexico Nursing Practice Act at least once per day.

(a) These medical needs include:

(i) skilled nursing interventions;

(ii) delivery of treatment;

(iii) monitoring for change of condition; and

(iv) adjustment of interventions and revision of services and plans based on assessed clinical needs.

(b) In addition to providing support to an eligible recipient with chronic health conditions, intense medical living supports are available to an eligible recipient who meets a high level of medical acuity and require short-term transitional support due to recent illness or hospitalization. This service will afford the core living support provider the time to update health status information and health care plans, train staff on new or exacerbated conditions and assure that the home environment is appropriate to meet the needs of the eligible recipient. Short-term stay in this model may also be utilized by an eligible recipient who meets the criteria that are living in a family setting when the family needs a substantial break from providing direct service. Both types of short-term placements require prior approval of DOH/DDSD. In order to accommodate referrals for short-term stays, each approved intense medical living provider must maintain at least one bed available for such short-term placements. If the short-term stay bed is occupied, additional requests for short-term stay will be referred to other providers of this service.

(c) The intense medical living provider will be responsible for providing the appropriate level of supports, 24 hours per day seven days a week, including necessary levels of skilled nursing based on assessed need. Daily nursing visits are required, however a nurse is not required to be present in the home during periods of time when skilled nursing services are not required or when an eligible recipient is out in the community. An on-call nurse must be available to staff during periods when a nurse is not present. Intense medical living supports require supervision by a registered nurse in compliance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

(d) Direct support personnel will provide services that include training and assistance with ADLs such as bathing, dressing, grooming, oral care, eating, transferring, mobility and toileting. These services also include training and assistance with instrumental activities of daily living (IADLs) including housework, meal preparation, medication assistance, medication administration, shopping, and money management.

(e) The intense medical living supports provider will be responsible for providing access to customized community support and employment as outlined in the eligible recipient's ISP. This includes any skilled nursing needed by the eligible recipient to participate in customized community support and development and employment services. This service must arrange transportation for all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options.

(f) Intense medical services must be provided in accordance with all requirements set forth by DOH/DDSD DDW service definition, all requirements outlined in the DDW service standards and the MAD rules.

[8.314.5.13 NMAC - Rp, 8.314.5.13 NMAC, 11-1-12]

8.314.5.14 NON-COVERED SERVICES: Only the services listed as covered waiver services are covered under the MAD DDW program. Medicaid non-waiver services may also be available to an eligible waiver recipient through state plan medicaid services. Medicaid does not cover room and board as waiver service or ancillary services.

[8.314.5.14 NMAC - Rp, 8.314.5.14 NMAC, 11-1-12]

8.314.5.15 INDIVIDUALIZED SERVICE PLAN (ISP): An ISP must be developed by an interdisciplinary team (IDT) of professionals in consultation with the eligible recipient and others involved in the eligible recipient's care. The ISP is developed using information relevant to the care of the individual. The ISP will be developed utilizing the service package available with the individual's NM SIS group. The ISP must be in accordance with policy and all requirements set forth by DOH/DDSD DDW services definition, all requirements outlined in the DDW service standards and the MAD rules. The ISP is submitted to DOH/DDSD or its designee for final approval. DOH/DDSD or its designee must approve any changes to the ISP. See 7.26.5 NMAC.

A. The IDT must review the treatment plan every 12 months or more often if indicated.

B. The ISP must contain the following information:

(1) statement of the nature of the specific needs of the eligible recipient;

(2) description of the functional level of the eligible recipient;

(3) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(4) description of intermediate and long-range goals, with a projected timetable for eligible recipient's attainment and the duration and scope of services;

(5) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provision for review and modification of the plan; and

(6) specification of responsibilities for areas of care, description of needs, and orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the eligible recipient.

C. All services must be provided as specified in the ISP.

[8.314.5.15 NMAC - Rp, 8.314.5.15 NMAC, 11-1-12]

8.314.5.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under this medicaid waiver, are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions

and documentation forms necessary for prior authorization and claims processing.

A. **Prior authorization:** To be eligible for DDW program services, a MAD eligible recipient must require the level of care (LOC) of services provided in an ICF-IID. LOC determinations are made by MAD or its designee. The ISP must specify the type, amount and duration of services. Certain procedures and services specified in the ISP may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that individuals are eligible for MAD, DDW services or other health insurance prior to the time services are furnished. An eligible recipient may not be institutionalized, hospitalized, or receive personal care option (PCO) services or other HCBS waiver services at the time DDW services are provided, except for certain case management services that are required to coordinate discharge plans or transition of services to DDW services.

C. **Reconsideration:** Providers who disagree with the denial of a prior authorization request or other review decisions may request a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions*.

[8.314.5.16 NMAC - Rp, 8.314.5.16 NMAC, 11-1-12]

8.314.5.17 REIMBURSEMENT: Waiver service providers must submit claims for reimbursement to the MAD medicaid management information system (MMIS) contractor for processing. Claims must be filed per the billing instructions in the medicaid policy manual. Providers must follow all medicaid billing instructions. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of waiver services is made at a predetermined reimbursement rate.

[8.314.5.17 NMAC - Rp, 8.314.5.17 NMAC, 11-1-12]

8.314.5.18 RIGHT TO A HEARING: The HSD/MAD must grant an opportunity for an administrative hearing as described in this section on the following circumstances and pursuant to 8.352.2.10 NMAC, *Recipient Hearings*. This rule is meant to be more specific than 8.352.2 NMAC and will be the controlling rule for any conflicts with 8.352.2 NMAC.

A. DDW eligible recipients may request a fair hearing when:

(1) a DDW eligible recipient has been determined not to meet the LOC requirement for waiver services;

(2) a DDW eligible recipient alleges that the SIS interviewer did not substantially follow the standard procedures (as found in the DD waiver service standards) for conducting a SIS assessment; or

(3) the service package does not adequately meet the health and safety needs of the eligible recipient; the DDW eligible recipient must develop and submit a budget within the NM SIS group placement and will receive a notice of fair hearing rights along with the decision regarding the proposed budget.

B. Notification of fair hearing rights: DDW eligible recipients are notified of their right to a fair hearing:

(1) when the SIS assessment is completed and the NM SIS group is sent to the DDW eligible recipient; and

(2) when a submitted budget is approved, partially approved, or denied.

C. Agency conference

(1) At the eligible recipient's request, or upon initiation by DOH/DDSD, an agency conference may be scheduled at any time prior to the date of the hearing to discuss the issues that are the subject of the fair hearing. The agency conference is optional and does not delay or replace the hearing process.

(2) The conference may include the eligible recipient and the eligible recipient's authorized representative, if applicable and DOH/DDSD staff. The purpose of the conference is to informally review the agency action and to determine whether the issues can be resolved by mutual agreement. The issues to be decided at the hearing may also be clarified or further defined. Regardless of the outcome of the agency conference, the hearing shall still be held as scheduled, unless the eligible recipient makes an oral or written withdrawal of the request for the hearing. An oral withdrawal shall be confirmed by the agency or designee in writing, sent to the eligible recipient, and allow for the eligible recipient to change his/her mind within ten days of the date of the confirmation letter.

[8.314.5.18 NMAC - N, 11-1-12]

8.314.5.19 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to an eligible recipient who requests a hearing and continuation of benefits within 13 calendar days of the date on the notice of fair hearing. The notice will include information on the right to continued benefits and on the eligible recipient's potential responsibility for repayment if the hearing decision is not in the eligible recipient's favor. Repayment of benefits shall be in accordance with 8.352.2.16 NMAC.

B. Once the eligible recipient requests a continuation of benefits, his/her budget that is in place at the time of the request is termed a continuation budget. The continuation budget may not be revised until the conclusion of the fair hearing process, unless a revision is agreed to in writing by the DDW eligible recipient (or appropriate representative) and DDSD.

[8.314.5.19 NMAC - N, 11-1-12]

HISTORY OF 8.314.5 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records – State Records Center and Archives.

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, 3/19/84.

History of Repealed Material:

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, Repealed 1/18/95.

8 NMAC 4.MAD.736.12 - Repealed 9/1/98; and

8 NMAC 4.MAD.736.412 - Repealed 9/1/98.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, Repealed 3/1/07.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, filed 2/15/07 is repealed effective 11/1/12

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

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

8.314.6.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

[8.314.6.1 NMAC - Rp, 8.314.6.1 NMAC, 10-15-12]

8.314.6.2 SCOPE: The rule applies to the general public.

[8.314.6.2 NMAC - Rp, 8.314.6.2 NMAC, 10-15-12]

8.314.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of

health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.314.6.3 NMAC - Rp, 8.314.6.3 NMAC, 10-15-12]

8.314.6.4 DURATION: Permanent.
[8.314.6.4 NMAC - Rp, 8.314.6.4 NMAC, 10-15-12]

8.314.6.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.
[8.314.6.5 NMAC - Rp, 8.314.6.5 NMAC, 10-15-12]

8.314.6.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.314.6.6 NMAC - Rp, 8.314.6.6 NMAC, 10-15-12]

8.314.6.7 DEFINITIONS:

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

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

C. **Authorized annual budget (AAB):** The eligible recipient works with his or her consultant to develop an annual budget request which is submitted to the third party assessor (TPA) for review and approval. The total annual amount of the mi via services and goods includes the frequency, the amount, and the duration of the waiver services and the cost of waiver goods approved by the TPA. Once approved, this is the annual approved budget (AAB).

D. **Brain injury (BI):** Eligible recipients (through age 65) with an injury to the brain of traumatic or acquired origin resulting in a total or partial functional disability or psychosocial impairment or both. The BI eligible recipient must have a documented BI diagnosis, as included in the international classification of diseases (ICD-9-CM or its successor).

E. **Category of eligibility (COE):** To qualify for a medical assistance program, an applicant must meet financial criteria and belong to one of the groups that the state has defined as eligible. An eligible recipient in mi via must belong to one of the categories of eligibility (COE) described in 8.314.6.13 NMAC.

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

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

H. **Eligible recipient:** An applicant meeting the financial and medical LOC criteria who is approved to receive MAD services through the mi via program.

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

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

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

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

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

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

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

P. **Level of care (LOC):** The level of care (LOC) required by an eligible recipient in an institution. An eligible recipient in the mi via program must be determined to need either the LOC required for admittance to a licensed nursing facility (NF) or an ICF/MR.

Q. **Mi via:** Mi via is the name of the Section 1915 (c) MAD self-directed HCBS waiver program through which an eligible recipient has the option to access services to allow him or her to remain in the community.

R. **Reconsideration:** An eligible recipient who disagrees with a clinical/medical utilization review decision or action may submit a written request to the TPA for reconsideration of the decision. The eligible recipient may submit the request for a reconsideration through the consultant or the consultant agency or may submit the request directly to MAD.

S. **Self-direction:** The process applied to the service delivery system wherein the eligible recipient identifies, accesses and manages the services (among the state-determined waiver services and goods) that meet his or her assessed therapeutic, rehabilitative, habilitative, health or safety needs to support the eligible recipient to remain in his or her community.

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

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

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

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

[8.314.6.7 NMAC - Rp, 8.314.6.7 NMAC, 10-15-12]

8.314.6.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.314.6.8 NMAC - Rp, 8.314.6.8 NMAC, 10-15-12]

8.314.6.9 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER:

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

B. Mi via is comprised of two MAD home and community-based waivers established under Section 1915(c) of the Social Security Act. One waiver is specifically for eligible recipients who meet the LOC otherwise provided in a nursing facility (NF). The second waiver is specifically for eligible recipients who meet the LOC otherwise provided in an ICF/MR.

(1) Both waivers are managed as a single self-directed program and are administered collaboratively by the DOH and HSD/MAD. MAD is responsible for the daily administration of mi via for eligible recipients living with disabilities, conditions associated with aging, and certain traumatic or acquired brain injuries who meet the LOC for admittance to an NF. DOH is responsible for the daily administration of mi via for eligible recipients living with developmental disabilities and medically fragile conditions who meet the LOC for admittance to an ICF/MR The DOH also manages the waiver for eligible recipients living with AIDS who meet the LOC for admittance to an NF.

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

[8.314.6.9 NMAC - Rp, 8.314.6.9 NMAC, 10-15-12]

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

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

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

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

(2) applies the information from the LOC documentation and the following assessments, long-term care assessment abstract (NF or ICF/MR), the comprehensive individual assessment (CIA), the universal assessment tool (UAT), or other state approved assessment tools, as appropriate for the category of eligibility, to assign the IBA for the eligible recipients that are medically eligible; and

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

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

(1) verify that the recipients are eligible for MAD services prior to making payment for services;

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

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

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

(5) process all payroll functions on behalf of the eligible recipients and EORs including:

(a) collect and process timesheets of employees;

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

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

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

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

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

(9) report any concerns related to the health and safety of the eligible recipient's or that the eligible recipient is not following the approved SSP and AAB to the consultant provider, MAD and DOH, as appropriate.

[8.314.6.10 NMAC - Rp, 8.314.6.10 NMAC, 10-15-12]

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

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

B. **General qualifications:**

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

(a) be at least 18 years of age;

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

(c) be able to communicate successfully with the eligible recipient;

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

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

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

(g) meet any other service specific qualifications, as specified in this rule and service standards.

(2) Vendors, including those providing professional services:

(a) shall be qualified to provide the service;

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

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

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

(e) if currently approved waiver providers, are to be in good standing with the appropriate state agency; and

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

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

(4) Individuals with legal responsibility to provide care (LRI), e.g., the parent (biological, legal or adoptive) of a minor child (under age 18) or a spouse of the eligible recipient, may be hired and paid for provision of waiver services (except consultant/support guide, assisted living, and customized community supports services) under extraordinary circumstances in order to assure the health and welfare of the eligible recipient, to avoid institutionalization when approved by MAD and provided that MAD is eligible to receive federal financial participation (FFP).

(a) Extraordinary circumstances include the inability of the LRI to find other qualified, suitable caregivers when the LRI would otherwise be absent from the home and, thus, the caregiver must stay at home to ensure the eligible recipient's health and safety.

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

(c) Services provided by LRIs must:

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

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

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

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

(i) a parent, parents in combination, or a spouse, may not provide more than 40 hours of services in a consecutive seven-day period; for parents of the eligible recipient, 40 hours is the total amount of service regardless of the number of eligible recipients under the age of 21who receive services through the mi via waiver;

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

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

(e) An eligible recipient must be offered a choice of providers. There must be written approval from MAD when an

eligible CoLTS (c) or BI recipient, or from DOH when an eligible DOH AIDS, DD or MF recipient chooses his or her spouse as a provider. This written approval must be documented in the SSP.

(f) Eligible recipients 16 years of age or older must be offered a choice of provider. There must be written approval from MAD when an eligible CoLTS (c) or BI recipient or from DOH when an eligible DOH AIDS, DD and MF recipient chooses his or her parent as a provider. This written approval must be documented in the SSP.

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

(5) Once enrolled, providers, vendors and contractors receive a packet of information from the eligible recipient or FMA, including billing instructions, and other pertinent materials. Mi via eligible recipients or legal representatives are responsible for ensuring that providers, vendors and contractors have received these materials and for updating them as new materials are received from the state MAD for CoLTS (c), and BI or DOH for AIDS, DD, and MF). MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, an eligible recipient or legal representative, or provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or legal representative, or provider, vendor, or contractor to access these instructions or ask for paper copies to be provided, to understand_the information provided and to comply with the requirements. The eligible recipient or legal representative, or provider, vendor, or contractor must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials.

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

(b) No provider agency is permitted to perform both LOC assessments and provide any services for the eligible recipients.

(c) Providers may market their services, but are prohibited from soliciting eligible recipients under any circumstances.

(6) The EOR is the individual responsible for directing the work of the eligible recipient's employees. MAD encourages an eligible recipient 18 years of age or older to be his or her own EOR. It is also possible to designate someone else to act as the EOR.

(a) An eligible recipient that is the subject of a plenary or limited guardianship or conservatorship may not be his or her own EOR.

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

(c) An EOR who lives outside New Mexico shall reside within 100 miles of the New Mexico state border. If the eligible recipient wants to have an EOR who resides beyond this radius, the eligible recipient must obtain written approval from MAD (when an eligible CoLTS (c) or BI recipient) or from DOH (when an eligible DOH AIDS, DD or MF recipient) prior to the EOR performing any duties. This written approval must be documented in the SSP.

(d) The eligible recipient's provider may not also be his/her EOR.

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

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

C. **Service specific qualifications for consultant services providers:** In addition to general requirements, a consultant provider shall ensure that all individuals hired or contracted consultant services meet the criteria specified in this section in addition to as well to perform all applicable rules and service standards.

(1) Consultant providers shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) **Qualifications of home health aide service providers:** Home health agency/homemaker agencies must hold a New Mexico current home health agency, rural health clinic, or federally qualified health center license. Home health aides

must have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program pursuant to 7.28.2.30 NMAC. Home health aides must also be supervised by a registered nurse licensed in New Mexico. Such supervision must occur at least once every 60 calendar days in the eligible recipient's home, and shall be in accordance with the New Mexico Nurse Practice Act and be specific to the eligible recipient's SSP.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) acupuncture and oriental medicine;

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

(c) chiropractic medicine;

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

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

(f) massage therapy;

(g) naprapathic medicine;

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

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

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

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

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

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

(c) have no DWI convictions or chargeable (at fault) accidents within the previous 24 months;

(d) have current CPR/first aid certification;

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

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

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

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

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

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

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

[8.314.6.11 NMAC - Rp, 8.314.6.11 NMAC, 10-15-12]

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

[8.314.6.12 NMAC - Rp, 8.314.6.12 NMAC, 10-15-12]

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

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

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

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

(3) is expected to continue indefinitely;

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

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

(6) the eligible recipient must have a developmental disability and intellectual disability or a specific related condition; related conditions as determined by the DOH/developmental disabilities supports division (DDSD); and

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

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

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

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

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

(b) require ICF/MR LOC.

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

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

E. **Brain-injury (BI):** Eligible recipients through age 65 with an injury to the brain of traumatic or acquired origin resulting in total or partial functional disability or psychosocial impairment or both. The BI eligible recipient must have a documented BI diagnosis, as included in the international classification of diseases (ICD-9-CM or its successor). The MAD usage of brain injury does not apply to brain injuries that are congenital, degenerative, induced by birth trauma or neurological disorders related to the aging process, or chemically caused brain injuries that are a result of habitual substance abuse. Additional criteria include:

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

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

psychosocial behavior, physical functions, information processing and speech; and

(3) the individual must require NF LOC.

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

[8.314.6.13 NMAC - Rp, 8.314.6.13 NMAC, 10-15-12]

8.314.6.14 ELIGIBLE RECIPIENT AND EOR RESPONSIBILITIES: Mi via eligible recipients have certain responsibilities to participate in the waiver. Failure to comply with these responsibilities or other program rules and service standards can result in termination from the program. The eligible recipient and EOR have the following responsibilities:

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

B. To participate in mi via, the eligible recipient must:

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

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

(3) collaborate with the consultant to develop an SSP using the IBA in accordance with mi via program rules and service standards;

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

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

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

(b) revisions to the AAB may occur within the SSP year, and the eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect;

(i) the SSP must be amended first to reflect a change in the eligible recipient's needs or circumstances before any revisions to the AAB can be requested;

(ii) other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year;

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

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

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

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

(8) report concerns or problems with any part of the mi via program to the consultant or if the concern or problem is with the consultant, to MAD or DOH;

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

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

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

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

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

(14) have monthly contact and meet face-to-face quarterly with the consultant.

C. Additional responsibilities of the eligible recipient or EOR:

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

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

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

(4) Hire, manage, and terminate employees.

(5) Maintain records and documentation.

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

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

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

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

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

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

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

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

(4) The eligible recipient commits medicaid fraud.

(5) The eligible recipient who is involuntarily terminated from mi via will be

offered a non self-directed waiver alternative. If transfer to another waiver is authorized by MAD and accepted by the eligible recipient, he/she will continue to receive the services and supports from mi via until the day before the new waiver services start. This will ensure that no break in service occurs. The mi via consultant and the service coordinator in the new waiver will work closely together with the eligible recipient to ensure that the eligible recipient's health and safety is maintained.

[8.314.6.14 NMAC - Rp, 8.314.6.14 NMAC, 10-15-12]

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

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

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

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

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

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

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

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

(1) **Contact requirements:** Consultant providers shall make contact with the eligible recipient in person or by telephone at least monthly for a routine follow-up. Consultant providers shall meet in person with the eligible recipient at least quarterly; one visit must be conducted in the eligible recipient's home. Quarterly visits will be conducted for the following purposes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) ALTSD/APS for eligible recipients age 18 years or older or CYFD/CPS for eligible recipients under 18 years for critical incidents involving abuse, neglect or exploitation; and

(ii) MAD, quality assurance bureau as well as the MCO, if applicable; the consultant provider shall fax all critical incidents in the standardized format provided by the CYFD/CPS and ALTSD/APS.

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

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

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

(b) arrange for participation of invitees and location;

(c) conduct the personal planning session;

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

(2) Elements of this report shall include:

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

(b) services from sources other than MAD to aid the eligible recipient;

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

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

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

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

E. **Living supports:**

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

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

(b) Personal care services are covered under the medicaid state plan as enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for waiver eligible recipients under 21 years.

(2) **Home health aide services:** Home health aide services provide total care or assist an eligible recipient 21 years and older in all activities of daily living. Home health aide services assist the eligible recipient in a manner that will promote an improved quality of life and a safe environment for the eligible recipient. Home health aide services can be provided outside the eligible recipient's home. State plan home health aide services are intermittent and provided primarily on a short-term basis. Mi via home health aide services are hourly services for eligible recipients who need this service on a more long-term basis. Home health aide services are not duplicative of homemaker services. Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks.

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

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

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

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

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

(4) **Customized in-home living supports:** Customized in-home living supports are related to the eligible recipient's qualifying condition or disability and enable him/her to live in his /her apartment or house. Services must be provided in homes/apartments owned or leased by the eligible recipient or in the eligible recipient's home.

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

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

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

F. **Community membership supports:**

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

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

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

(c) Community direct support services include:

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

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

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

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

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

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

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

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

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

(i) job identification and development activities;

(ii) employer negotiations;

(iii) job restructuring;

(iv) job sampling; and

(v) job placement.

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

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

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

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

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

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

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

(3) **Customized community supports:** Customized community supports can include participation in congregate community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills for an eligible recipient. Customized community supports may include adult day habilitation, adult day health and other day support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings. These services are provided at least four or more hours per day one or more days per week as specified in the eligible recipient's SSP.

G. **Health and wellness:**

(1) **Extended state plan skilled therapy for eligible recipients 21 years and older:** Enhanced state plan skilled therapy for adults includes physical therapy, occupational therapy or speech language therapy. CoLTS services are provided when skilled therapy services under the state plan are exhausted or not a benefit. Eligible recipients 21 years and older on mi via access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to eligible recipients 21 years or older in mi via focus on improving functional independence, health maintenance, community integration, socialization, and exercise, or enhance support and normalization of family relationships.

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

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

(ii) treat a specific condition clinically related to the eligible recipient's disability;

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

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

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

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

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

(iii) skills assessments and treatment;

(iv) assistive technology recommendations and usage training;

(v) guidance to family members and caregivers;

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

(vii) treating specific conditions clinically related to the eligible recipient's developmental disability;

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

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

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

(i) improve or maintain the eligible recipient's capacity for successful communication or to lessen the effects of the

eligible recipient's loss of communication skills; or

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

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

(d) **Behavior support consultation:** Behavior support consultation services consist of functional support assessments, treatment plan development, and training and support coordination for the eligible recipient's related to behaviors that compromise the eligible recipient's quality of life. Based on the eligible recipient's SSP, services are delivered in an integrated, natural setting, or in a clinical setting. Behavior support consultation:

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

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

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

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

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

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

(f) **Private duty nursing for adults:** Private duty nursing for eligible recipients 21 years or older includes activities, procedures, and treatment for the eligible recipient's physical condition, physical illness or chronic disability. Services include medication management, administration and teaching, aspiration precautions, feeding tube management, gastrostomy and jejunostomy care, skin care, weight management, urinary catheter management, bowel and bladder care, wound care, health education, health screening, infection control, environmental management for safety, nutrition management, oxygen management, seizure management and precautions, anxiety reduction, staff supervision, behavior and self-care assistance.

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

(a) **Acupuncture:** Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. See acupuncture and oriental medicine practitioners 16.2.1 NMAC.

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

(c) **Chiropractic:** Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis, for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health. See 16.4.1 NMAC.

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

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

(f) **Massage therapy:** Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, an eligible recipient's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities. See massage therapists 16.7.1 NMAC.

(g) **Naprapathy:** Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage.

Based on the concept that constricted connective tissue (ligaments, muscles, and tendons) interfere with nerve, blood, and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. See naprapathic practitioners, 16.6.1 NMAC.

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

(i) **Play therapy:** Play therapy is a variety of play and creative arts techniques utilized to alleviate chronic, mild and moderate psychological and emotional conditions for an eligible recipient that are causing behavioral problems or are preventing the eligible recipient from realizing his/her potential. The play therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the eligible recipient's direction.

H. **Other supports:**

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

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

(a) testing and maintaining equipment;

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

(c) 24-hour monitoring for alarms;

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

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

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

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

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

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

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

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

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

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

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

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

(vii) facilitate activities of daily living.

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

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

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

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

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

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

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

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

(d) The environmental modification provider must: ensure proper design criteria is addressed in the planning and design of the adaptation; be a licensed and insured contractor(s) or approved vendor(s) that provides construction/

remodeling services; provide administrative and technical oversight of construction projects; provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the participant's residence; and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

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

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

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

[8.314.6.15 NMAC - Rp, 8.314.6.15 NMAC, 10-15-12]

8.314.6.16 NON-COVERED SERVICES: Non-covered services include, but are not limited to the following:

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

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

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

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

E. experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC *Experimental or Investigational Procedures, Technologies or Therapies*;

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

G. any goods or services that are to be used primarily for recreational or diversional purposes;

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

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

J. gas cards and gift cards;

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

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

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

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

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

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

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

S. regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, *except* upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the eligible recipient's qualifying condition or disability; requests must include documentation that the adapted vehicle is the eligible recipient's primary means of transportation;

T. clothing and accessories, except specialized clothing based on the eligible recipient's disability or condition;

U. training expenses for paid employees;

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

W. consumer electronics such as computers, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.15 NMAC; no more than one of each type of item may be purchased at one time; and consumer electronics may not be replaced more frequently than once every three years;

X. cell phone services that include: fees for data; or more than one cell phone line per eligible recipient; and

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

[8.314.6.16 NMAC - Rp, 8.314.6.16 NMAC, 10-15-12]

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

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

(1) **Assessments:**

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

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

(c) The eligible recipient and the consultant will assure that the SSP addresses

the information and concerns, if any, identified through the assessment process.

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

(2) **Pre-planning:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the IBA.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Budgetary allotments are based on calculations developed by the state for each mi via population group, including AIDS, former disabled and elderly (D&E) now CoLTS (c), DD or MF waiver, and BI category of eligibility, utilizing historical traditional waiver care plan authorized budgets within the population, minus the case management costs, and minus a 10 percent discount.

(2) The determination of each mi via eligible recipient's sub-group is based on a comprehensive assessment. The eligible recipient then receives the IBA available to that category of need, according to the eligible recipient's age.

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

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

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

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

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

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

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

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

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

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

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

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

SSP; and

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

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

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

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

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

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

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

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

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

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

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

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

E. **Modification of the SSP:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) the eligible recipient may submit additional supportive documentation by others involved in the eligible recipient's care, such as a current

individual service plan if the eligible recipient is transferring from another waiver, a recent evaluation from a specialist or therapist, a recent discharge plan, relevant medical records or other documentation or recent statements from family members, friends or other support individuals;

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

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

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

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

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

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

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

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

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

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

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

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

[8.314.6.17 NMAC - Rp, 8.314.6.17 NMAC, 10-15-12]

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

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

B. **Eligibility determination:** To be eligible for mi via program services, eligible recipients must

require the LOC of services provided in an ICF-MR for eligible recipients identified as DD and MF, or in an NF for participants identified as CoLTS (c), diagnosed with AIDS, or BI. Prior authorization of services does not guarantee that applicants/eligible recipients are eligible for medicaid.

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

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

[8.314.6.18 NMAC - Rp, 8.314.6.18 NMAC, 10-15-12]

8.314.6.19 REIMBURSEMENT:

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

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

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

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

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

(4) mi via eligible recipients and mi via service providers and vendors must follow all FMA billing instructions; and

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

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

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

[8.314.6.19 NMAC - Rp, 8.314.6.19 NMAC, 10-15-12]

8.314.6.20 RIGHT TO A HEARING:

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

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

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

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

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

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

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

B. DOH and its counsel, if necessary, shall participate in any fair hearing involving a DD or MF eligible recipient, or an eligible recipient diagnosed with AIDS. HSD/MAD, and its counsel, if necessary, may participate in fair hearings.

[8.314.6.20 NMAC - Rp, 8.314.6.20 NMAC, 10-15-12]

8.314.6.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

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

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

[8.314.6.21 NMAC - Rp, 8.314.6.21 NMAC, 10-15-12]

8.314.6.22 GRIEVANCE/COMPLAINT SYSTEM: HSD/MAD and DOH operate a grievance/complaint system that affords eligible recipients the opportunity to register grievances or complaints concerning the provision of services under the mi via program. HSD/MAD administers the grievance/complaint process for eligible recipient's in the mi via NF LOC waiver who are brain injured or disabled or elderly. DOH administers the grievance/complaint process for eligible recipients in the ICF/MR level of care (LOC) waiver and for eligible recipients in the AIDS program who are in the NF LOC waiver. Eligible recipients may register complaints with either department via e-mail, mail or phone. Complaints will be referred to the appropriate department for resolution. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.

A. A grievance or complaint is required to be addressed within 30 calendar days from the date it was received.

B. Upon receipt of the grievance or complaint, DOH or HSD/MAD enters it into the complaint tracker and informs the contractor or provider of the grievance or complaint. DOH or HSD/MAD notifies the eligible recipient within one day of receipt of the grievance or complaint who will be responsible for resolution of the grievance or complaint.

C. DOH or HSD/MAD gives the contractor or provider 14 calendar days to resolve the grievance or complaint. If the grievance or complaint contains an issue that may compromise the health or safety of the participant, DOH or HSD/MAD remains involved with the parties until the grievance or complaint is resolved

D. The contractor or provider shall notify DOH or HSD/MAD of their progress toward resolution of the grievance or complaint. If the grievance or complaint has not been resolved in 14 calendar days, DOH or HSD/MAD becomes involved to ensure that an initial response is issued within 30 calendar days of receipt of the grievance or complaint.

[8.314.6.22 NMAC - Rp, 8.314.6.22 NMAC, 10-15-12]

History of 8.314.6 NMAC:

History of Repealed Material:

8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 11-16-2006 - Repealed effective 4-1-2011

8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 3-15-2011 - Repealed effective 10-15-2012.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.290.400 NMAC, Sections 1, 3, 6, 7, 9 and 10, effective 11/1/12.

8.290.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[2/1/95; 8.290.400.1 NMAC - Rn, 8 NMAC 4.WAV.000.1, 5/1/02; A, 11/1/12]

8.290.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. [~~See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991)~~] See NMSA 1978, Section 27-2-12 et seq.
[2/1/95; 8.290.400.3 NMAC - Rn, 8 NMAC 4.WAV.000.3, 5/1/02; A, 11/1/12]

8.290.400.6 OBJECTIVE: The objective of [~~these regulations~~] this rule is to provide eligibility criteria for the medicaid program.
[2/1/95; 8.290.400.6 NMAC - Rn, 8 NMAC 4.WAV.000.6, 5/1/02; A, 11/1/07; A, 11/1/12]

8.290.400.7 DEFINITIONS:

[~~A. **Individual service plan (ISP):** A treatment plan for a recipient that includes the recipient's needs, functional level, intermediate and long range goals, statement for achieving the goals and specifies responsibilities for the care needs. The plan determines the services allocated to an individual within program allowances.~~

~~B. **Letter of allocation:** Written notice to the applicant that they may proceed with the HCBSW application process.~~

~~C. **Level of care:** The level of nursing care needed by an individual.~~

~~D. **Prospective:** A period of time starting with the date of application going forward.~~

~~E. **Restricted coverage:** Medicaid eligibility without long term care services coverage.~~

~~F. **Unduplicated recipient positions (UDR):** Space available in a particular HCBSW program.~~

~~G. **Waiver:** Permission from the centers for medicaid and medicare services to cover a particular population or service not ordinarily allowed.~~]

A. **Adaptive behavior:** The effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for their age and cultural group.

B. **Developmental disability:** For the purposes of the DD waiver, a developmental disability is limited to an intellectual disability or a specific related condition as defined by the department of health/developmental disabilities supports division (DOH/DDSD) that is likely to continue indefinitely and results in substantial functional limitation s in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.

C. **Developmental period:** The time between birth and the 18th birthday.

D. **Disability determination services unit (DDSU):** The unit that determines disability as described in 8.200.420.11 NMAC.

E. **General intellectual functioning:** The results of one or more individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.

F. **Individual service plan (ISP):** A treatment plan for an eligible recipient that includes the eligible recipient's needs, functional level, intermediate and long range goals, statement for achieving the goals and specifies responsibilities for the care needs. The plan determines the services allocated to the eligible recipient within program allowances.

G. **Institutional care facility for individuals with intellectual disabilities (ICF/IID):** This term replaces all references to institutional care facility for mental retardation (ICF/MR).

H. **Intellectual disability:** Refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Intellectual disability replaces all references to mental retardation.

I. **Letter of allocation:** Written notice to the applicant that they may proceed with the home and community-based services waiver (HCBSW) application process.

J. **Level of care:** The level of nursing care needed by the eligible recipient.

K. **Prospective:** A period of time starting with the date of application going forward.

L. **Restricted coverage:** Medicaid eligibility without long term care services coverage.

M. **Significantly subaverage intellectual functioning:** IQ of 70 or below.

N. **Unduplicated recipient positions (UDR):** Space available in a particular HCBSW program.

O. **Waiver:** Permission from the centers for medicaid and medicare services (CMS) to cover a particular population or service not ordinarily allowed.
[8.290.400.7 NMAC - N, 11/1/07; A, 11/1/12]

8.290.400.9 HOME AND COMMUNITY-BASED SERVICES WAIVER - Category 090, 091, 092, 093, 094, 095, 096: The human services department (HSD) is the single state agency designated to administer the medicaid program in New Mexico. The department of health (DOH)[~~, the aging and long term services department (ALTSD)~~] and the human services department are charged with developing and implementing home and community-based services waiver (HCBSW) to medicaid applicants/recipients who meet both financial and medical criteria for an institutional (nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care. Provision of these services under a waiver allows applicants/recipients to receive the care required at home at less cost than in an institution. The services to be furnished under the waiver must be cost-effective. This means the aggregate cost of care must be an amount less than the cost of maintaining individuals in institutions at the appropriate level of care. The types of services for which [~~medicaid~~] MAD eligible recipients are eligible vary based on the individual waiver. See medical assistance division program manual for the standards for individual waiver of covered services and program rules for all waiver services. The following sections contain the eligibility rules for all waiver services.
[2/1/95; 8.290.400.9 NMAC – Rn, 8 NMAC 4.WAV.400 & A, 5/1/02; A/E, 12-1-06; A, 11/1/07; A, 11/1/12]

8.290.400.10 BASIS FOR DEFINING THE GROUP: Eligibility for applicants/recipients who apply for waiver services is determined as if he or she were actually institutionalized, although this requirement has been waived. Entry into some of the waiver programs may be based upon the number of unduplicated eligible recipient positions (UDRs) (i.e., slots). Some waiver categories require [~~individuals~~] eligible recipients to be placed on a central registry. The individual waiver program manager is responsible for notifying ISD when an [~~individual~~] eligible recipient is allocated into a waiver program.

A. **[~~Disabled and elderly (D&E) waiver:~~] Coordination of long term-services (CoLTS) waiver:** The [~~disabled and elderly~~] CoLTS waiver, formerly known as the disabled and elderly (D&E) waiver, identified as identified as

categories 091 (elderly), 093 (blind) and 094 (disabled) was approved effective July 1983, subject to renewal. To qualify as disabled or blind for the purposes of this waiver, disability or blindness must have been determined to exist by the disability determination [~~contractor (DDC)~~] services unit (DDSU). To qualify as an elderly person for purposes of this waiver, the applicant/recipient must be 65 years of age or older. Applicants/recipients must also meet both the financial and non-financial eligibility requirements and meet the medical level of care for nursing facility services.

~~[B. **Developmentally disabled (DD) waiver:** The developmental disabled waiver identified as category 096 was approved effective July 1984, subject to renewal. This waiver is designed to furnish services to applicants/recipients who meet the definition of a developmental disability and mental retardation or specific related condition as determined by the department of health and the DDC in accordance with the approved DD waiver criteria, including the following:~~

~~(1) the individual has a developmental disability, defined as a severe chronic disability, other than mental illness, that:~~

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

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

~~(c) is expected to continue indefinitely;~~

~~(d) results in substantial functional limitations in three or more of the following areas of major life activity:~~

~~(i) self-care;~~

~~(ii) receptive and expressive language;~~

~~(iii) learning;~~

~~(iv) mobility;~~

~~(v) self-direction;~~

~~(vi) capacity for independent living; and~~

~~(vii) economic self-sufficiency; and~~

~~(e) reflects the person's need for a combination and sequence of special or interdisciplinary treatment, generic or other support and services that are of lifelong or extended duration and are individually planned and coordinated.~~

~~(2) The individual also has mental retardation or a specific related condition, limited to cerebral palsy, autism (Asperger syndrome), seizure disorders, chromosomal disorders (e.g. downs), syndrome disorders, inborn errors of metabolism, and developmental disorders of brain formation.~~

~~(3) The individual must also require the level of care provided in an intermediate care facility for the mentally retarded (ICF-MR), and meet all other applicable financial and non-financial eligibility requirements.~~]

B. Developmental disabilities (DD) waiver: The developmental disabilities waiver identified as category 096 was approved effective July 1984, subject to renewal. Developmental disabilities waiver services are intended for eligible recipients who have developmental disabilities limited to intellectual disability (IID) or a specific related condition as determined by the DOH/DDSD. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The eligible recipient must also require the level of care provided in an intermediate care facility for individuals with developmental disabilities (ICF/IID), in accordance with 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements.

(1) Intellectual disability: An individual is considered to have MR/ID if she/he has significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(2) Specific related condition: An individual is considered to have a specific related condition if she/he has a severe chronic disability, other than mental illness, that meets all of the following conditions:

(a) is attributable to:

(i) cerebral palsy or seizure disorder; or

(ii) is attributable to autistic disorder (as described in the fourth edition of the diagnostic and statistical manual of mental disorders); or

(iii) is attributable to chromosomal disorders (e.g. down), syndrome disorders, inborn errors of metabolism, or developmental disorders of the brain formation limited to the list in Paragraph (3) below;

(b) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability and requires treatment or services similar to individuals with ID;

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

(d) is likely to continue indefinitely; and

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

(3) List of chromosomal disorders (e.g., down) syndrome disorders, inborn errors of metabolism or developmental disorders of the bring formation.

(a) **chromosomal disorders:** autosomes: 4p-, trisomy 4p, trisomy 8, 5p-, 9p-, trisomy 9p, trisomy 9p mosaic, partial trisomy 10q, 13q-, ring 13, trisomy 13 (Patau), 18p-, 18q-, trisomy 18 (Edwards), Ttisomy 20p, G (21,22) monosomy/deletion, trisomy 21 (down), translocation 21 (down), "cat-eye" syndrome; Prader-Willi syndrome (15);

(i) x-linked mental retardation: Allan syndrome; Atkin syndrome; Davis syndrome; Fitzsimmons syndrome; fragile x syndrome; fragile x phenotype (no fragile site); Gareis syndrome; glycerol kinase deficiency; Golabi syndrome; Homes syndrome; Juberg syndrome; Lujan syndrome; Renpenning syndrome; Schimke syndrome; Vasquez syndrome; nonspecific x-linked mental retardation;

(ii) other x chromosome disorders: xo syndrome (Turner); xyy syndrome; xxy syndrome (Klinefelter); xxyy syndrome; xxxy syndrome; xxxx syndrome; xxxxy syndrome; xxxxx syndrome (penta-x);

(b) **syndrome disorders:**

(i) neurocutaneous disorders: ataxia-telangiectasia (Louis-Bar); basal cell nevus syndrome; dyskeratosis congenital; ectodermal dysplasia (hyperhidrotic type); ectromelia ichthyosis syndrome; focal dermal hypoplasia (Goltz); ichthyosis-hypogonadism syndrome, incontinentia pigmenti (Bloch-Sulzberger); Ito syndrome; Klippel-Trenauney syndrome; linear sebaceous nevus syndrome; multiple lentigines syndrome; neurofibromatosis (Type 1); poikiloderma (Rothmund-Thomsen); Pollitt syndrome; Sjogren-Larsen syndrome; Sturge-Weber syndrome; tuberous sclerosis; xeroderma pigmentosum;

(ii) **muscular disorders:** Becker muscular dystrophy; chondrodystrophic myotonia (Schwartz-Jampel); congenital muscular dystrophy; Duchenne muscular dystrophy; myotonic muscular dystrophy;

(iii) **ocular disorders:** Aniridia-Wilm's tumor syndrome; anophthalmia syndrome (x-linked); Leber amaurosis syndrome; Lowe syndrome; microphthalmia-corneal opacity-spasticity syndrome; Norrie syndrome; oculocerebral syndrome with hypopigmentation; retinal degeneration-trichomegaly syndrome; septo-optic dysplasia;

(iv) **craniofacial disorders:** acrocephaly-cleft lip-radial aplasia syndrome; acrocephalosyndactyly;type 1 (Apert); type 2 (Apert); type 3 (Saethre-Chotzen); type 6 (Pfeiffer); Carpenter syndrome with absent digits and cranial defects; Baller-Gerold syndrome; cephalopolysyndactyly (Greig) "cloverleaf-skull" syndrome; craniofacial dysostosis (Crouzon); craniotelencephalic dysplasia; multiple synostosis syndrome;

(v) **skeletal disorders:** acrodysostosis, CHILD syndrome; chondrodysplasia punctata (Conradi-Hunerman type); chondroectodermal dysplasia; Dyggve-Melchior-Clausen syndrome; frontometaphyseal dysplasia; hereditary osteodystrophy (Albright); hyperostosis (Lenz-Majewski); hypochondroplasia; Klippel-Feil syndrome; Nail-patella syndrome; osteopetrosis (Albers-Schonberg); pyknodysostosis; radial aplasia-thrombocytopenia syndrome; radial hypoplasia pancytopenia syndrome (Fanconi); Roberts-SC phocomelia syndrome;

(c) **inborn errors of metabolism:**

(i) **amino acid disorders:** phenylketonuria: phenylalanine hydroxylase (classical, Type 1); dihydropteridine reductase (type 4); dihydrobiopterin synthetase (type 5); histidinemia; gamma-glutamylcysteine synthetase deficiency; hyperlysinemia; lysinuric protein intolerance; hyperprolinemia; hydroxyprolinemia; sulfite oxidase deficiency; iminoglycinuria; branched-chain amino acid disorders: hypervalinemia; hyperleucine-isoleucinemia; maple-syrup urine disease; isovaleric academia, glutaric academia (type 2); 3-hydroxy-3-methylglutaryl CoA lyase deficiency; 3-kethothiolase deficiency;,biotin-dependent disorders: holocarboxylase deficiency; biotinidase deficiency; propionic academia: type A; Type BC; methylmalonic academia: mutase type (mut+); cofactor affinity type (mut-); adenosylcobalamin synthetase type (cbl A); ATP: cobalamin adenosyltransferase type (cbl B), with homocystinuria, type 1 (cbl C), with homocystinuria, type 2 (cbl D); folate-dependent disorders: congenital defect of folate absorption; dihydrofolate reductase deficiency; methylene tetrahydrofolate reductase deficiency; homocystinuria; hypersarcosinemia; non-ketotic hyperglycinemia; hyper-beta-alaninemia; carnosinase deficiency; homocarnosinase deficiency; Hartnup disease; methionine malabsorption (oasthouse urine disease);

(ii) **carbohydrate disorders:** glycogen storage disorders: type 1, with hypoglycemia (von Gierke); type 2 (Pompe); galactosemia; fructose-1, 6-diphosphatase deficiency; pyruvic acid disorders: pyruvate dehydrogenase complex (Leigh); pyruvate carboxylase deficiency; mannosidosis; fucosidosis; aspartylglucosaminuria;

(iii) **mucopolysaccharide disorders:** alpha-L-iduronidase deficiency: Hurler type; Scheie type, Hurler-Scheie type; iduronate sulfatase deficiency (Hunter type); Heparan N-sulfatase deficiency (Sanfilippo 3A type); N-acetyl-alpha-D-glucosaminidase deficiency (Sanfilippo 3B type); Acetyl CoA; glucosaminide N-acetyltransferase deficiency (Sanfilippo 3C type); N-acetyl-alpha D-glucosaminide 6-sulfatase deficiency (Sanfilippo 3D type); beta-glucuronidase deficiency (Sly type);

(iv) **mucolipid disorders:** alpha-neuraminidase deficiency (type1); N-acetylglucosaminyl phosphotransferase deficiency: I-cell disease (Type 2); Pseudo-Hurler syndrome (type 3); mucolipidosis type 4;

(v) **urea cycle disorders:** carbamyl phosphate synthetase deficiency; ornithine transcarbamylase deficiency; argininosuccinic acid synthetase deficiency (citrullinemia); argininosuccinic acid (ASA) lyase deficiency; arginase deficiency (argininemia);

(vi) **nucleic acid disorders:** Lesch-Nyhan syndrome (HGPRTase deficiency); orotic aciduria; xeroderma pigmentosum (group A); DeSanctis-Cacchione syndrome;

(vii) **copper metabolism disorders:** Wilson disease; Menkes disease;

(viii) **mitochondrial disorders:** Kearns-Sayre syndrome; MELAS syndrome; MERRF syndrome; cytochrome c oxidase deficiency; other mitochondrial disorders;

(ix) **peroxisomal disorders:** Zellweger syndrome; adrenoleukodystrophy: neonatal (autosomal recessive); childhood (x-linked); infantile Refsum disease; hyperpipecolic academia; chondrodysplasia punctata (rhizomelic type);

(d) **developmental disorders of brain formation:**

(i) neural tube closure defects: anencephaly; spina bifida; encephalocele;

(ii) brain formation defects: Dandy-Walker malformation; holoprosencephaly; hydrocephalus: aqueductal stenosis; congenital x-linked type; Lissencephaly; pachygyria; polymicrogyria; schizencephaly;

(iii) cellular migration defects: abnormal layering of cortex; colpocephaly; heterotopias of gray matter; cortical microdysgenesis

(iv) intraneuronal defects: dendritic spine abnormalities; microtubule abnormalities;

(v) acquired brain defects: hydranencephaly; porencephaly; and

(vi) primary (idiopathic) microcephaly.

C. **Medically fragile (MF) waiver:** The medically fragile (MF) waiver identified as category 095 was established effective August, 1984 subject to renewal. [~~To be eligible for the medically fragile waiver, an applicant/recipient~~] Eligible recipients must meet the level of care required for admission to an intermediate care facility [~~for the mentally retarded (ICF/MR), and~~] for individuals with intellectual disabilities (ICF-IID), meet all other applicable financial and non-financial eligibility requirements and must have:

[~~(1) To qualify for the MF waiver an individual must:~~

~~(a) have~~] (1) a developmental disability, developmental delay, or be at risk for developmental delay as determined by the [~~DDC~~] DDSU, and

[~~(b) be diagnosed with~~] (2) a diagnosis a medically fragile condition prior to the age of 22, defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary, and which is characterized by one or more of the following:

[~~(i)~~] (a) a life threatening condition characterized by reasonably frequent periods of acute exacerbation, which require frequent medical supervision or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

[~~(ii)~~] (b) frequent, time-consuming administration of specialized treatments, which are medically necessary;

[~~(iii)~~] (c) dependency on medical technology such that without the technology a reasonable level of health could not be maintained; examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen; and

[~~(iv)~~] (d) periods of acute exacerbation of a life-threatening condition, the need for extraordinary supervision or observation, frequent or time-consuming administration of specialized treatments, dependency on mechanical (life) support devices, and developmental delay or disability.

D. **Acquired immunodeficiency syndrome (AIDS) and AIDS related condition (ARC) waiver:** The acquired immunodeficiency syndrome (AIDS) and AIDS related condition waiver designated as category 090, was established effective July 1987, subject to renewal. This waiver serves [~~applicants/recipients~~] eligible recipients diagnosed with AIDS/ARC. [~~Applicants/recipients~~] Eligible recipients must require [~~institutional~~] nursing facility level of care and meet all other applicable financial and non-financial eligibility requirements.

E. **Brain injury (BI) [~~under the mi via waiver~~]:** Brain injury services are [~~only available through the mi via waiver, and are~~] designated as category 092. [~~The mi via waiver, administered by the ALTSD, is effective December 1, 2006 and is subject to renewal.~~] To qualify for purposes of this waiver, the [~~applicants/~~

~~recipient~~] eligible recipient must be under 65 years of age at the time of approval, meet all other applicable financial and non-financial eligibility requirements, require nursing facility level of care and have a brain injury diagnosis, as defined by the state. Brain injury is defined as:

(1) an injury to the brain of traumatic or acquired origin [~~resulting in total or partial functional disability or psychosocial impairment or both. Additional criteria include the following~~] including:

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

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

(3) the term "brain injury" does not apply to injuries that are congenital, degenerative, induced by birth trauma or neurological disorders related to the aging process, or chemically caused brain injuries that are a result of habitual substance abuse[~~; the BI participant must have a documented BI diagnosis, as defined by the state; a list of applicable international classification of disease (ICD9) codes can be obtained from ALTSD or HSD/MAD; and~~

~~(4) individuals who require nursing facility level of care~~].

[2/1/95; 3/15/96; 8.290.400.10 NMAC – Rn, 8 NMAC 4.WAV.402 & A, 5/1/02; A/E, 12-1-06; A, 11/1/07; A, 11/1/12]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.290.600 NMAC, Sections 1, 3, 6 and 9-12 and 14, effective November 1, 2012.

8.290.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

[2/1/95; 8.290.600.1 NMAC - Rn, 8 NMAC 4.WAV.000.1, 5/1/02; A, 11/1/12]

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

[2/1/95; 8.290.600.3 NMAC - Rn, 8 NMAC 4.WAV.000.3, 5/1/02; A, 11/1/12]

8.290.600.6 OBJECTIVE: [~~The objective of these regulations is to provide eligibility criteria for the medicaid program.~~] The objective of this rule is to provide eligibility criteria for the medical assistance division (MAD) programs.

[2/1/95; 8.290.600.6 NMAC - Rn, 8 NMAC 4.WAV.000.6, 5/1/02; A, 11/1/07; A, 11/1/12]

8.290.600.9 BENEFIT DESCRIPTION: [~~An applicant/recipient who is eligible for medicaid under any of the waiver categories is~~] Eligible recipients are eligible for specified services available under the particular waiver and ancillary services available under the general medicaid program. See specific program policy sections for covered services.

[2/1/95; 8.290.600.9 NMAC - Rn, 8 NMAC 4.WAV.600, 5/1/02; A, 11/1/12]

8.290.600.10 BENEFIT DETERMINATION: Application for the waiver programs is made using the "application/redetermination of eligibility for medical assistance of aged, blind, and disabled individuals" (form MAD 381). Upon notification by the appropriate program manager that an unduplicated recipient (UDR) is available for waiver services, applicants are registered on the [~~ISD2~~] income support division eligibility system. Applications must be acted upon and notice of approval, denial, or delay sent out within [~~30~~] 45 calendar days from the date of application, or within [~~60~~] 90 calendar days if a disability determination is required from the [~~DDC~~] DDSU. The [~~applicant/recipient~~] eligible recipients must assist in completing the application, may complete the form [~~himself~~] themselves, or may receive help from a relative, friend, guardian, or other designated representative. To avoid a conflict of interest, a case manager or any other [~~medicaid~~] MAD provider may not complete the application or be a designated representative.

A. **Representatives applying on behalf of individuals:** [~~If a representative makes application on behalf of the applicant/recipient, that representative will continue to be relied upon for information regarding the applicant's/recipient's circumstances. The ISD worker will send all notices to the applicant/recipient in care of the representative.~~] If a representative makes application on behalf of the eligible recipient, that representative will continue to be relied upon for information regarding the eligible recipient's circumstances. The ISD caseworker will send all notices to the eligible recipient in care of the representative.

B. **Additional forms:** The following forms are also required as part of the application process:

(1) the [~~applicant/recipient~~] eligible recipient or representative must complete and sign the primary freedom of choice of case management agency form at the time of allocation; and

(2) the [~~applicant/recipient~~] eligible recipient or representative must sign the applicant's statement of understanding at the time waiver services are declined or terminated.

C. **Additional information furnished during application:** [~~The ISD worker provides an explanation of the waiver programs, including, but not limited to, income and resource limits and possible alternatives, such as institutionalization. The ISD worker refers potentially eligible applicants/recipients to the social security administration to apply for supplemental security income (SSI) benefits. If a disability decision by the DDC is required, but has not been made, the ISD worker must follow established procedures to refer the case for evaluation.~~] The ISD caseworker provides an explanation of the waiver programs, including, but not limited to, income and resource limits and possible alternatives, such as institutionalization. The ISD caseworker refers potentially eligible recipients to the social security administration to apply for supplemental security income (SSI) benefits. If a disability decision by the DDSU is required, but has not been made, the ISD caseworker must follow established procedures to refer the case for evaluation.

[2/1/95; 1/1/97; 8.290.600.10 NMAC - Rn, 8 NMAC 4.WAV.620 & A, 5/1/02; A, 11/1/07; A, 11/1/12]

8.290.600.11 INITIAL BENEFITS:

A. The application for home and community-based services waiver is approved when the following factors of eligibility have been met: financial, non-financial, and level of care. An application will be initiated when the ISD [~~worker~~] caseworker is notified by the appropriate program manager that a UDR position is available for the registrant (with the exception of the AIDS waiver). After the individualized service plan has been in effect for 30 days or if it can be reasonably anticipated that services will be in effect for 30 days, the application is approved effective the first day of the month of the start date of the individualized service

plan, unless income/resources deemed to a minor child from his parents results in the child's ineligibility for the initial month. The eligibility start date is based on the date of application or the start date of the ISP, whichever is later. See 8.290.500.17 NMAC, DEEMING RESOURCES, and 8.290.500.21 NMAC, DEEMED INCOME. Following initial approval, waiver services must be provided to eligible waiver recipients within 90 calendar days of the approval.

B. **Notice of determination:** Applicants determined to be ineligible for waiver services are notified of the reason for the denial and provided with an explanation of appeal rights.

C. Applicants determined to be eligible for waiver services are notified of the approval.

[2/1/95; 1/1/97; 8.290.600.11 NMAC - Rn, 8 NMAC 4.WAV.623 & A, 5/1/02; A, 11/1/07; A, 11/1/12]

8.290.600.12 ONGOING BENEFITS:

A. **Regular reviews:** A complete redetermination of eligibility must be performed annually by the ISD [~~worker~~] caseworker for each open case. The redetermination includes contact with the [~~applicant/recipient~~] eligible recipient or his representative to review financial and non-financial eligibility.

B. **Additional reviews:** Additional reviews are scheduled by the ISD [~~worker~~] caseworker depending upon the likelihood that the [~~applicant's/ recipient's~~] eligible recipient's income, resources or medical condition will change. The following are examples of frequently encountered changes which affect eligibility:

(1) social security cost-of-living increases;

(2) VA cost-of-living increases;

(3) rental income may be sporadic and require review every three months; and

(4) level of care review.

[2/1/95, 1/1/97; 8.290.600.12 NMAC - Rn, 8 NMAC 4.WAV.624 & A, 5/1/02; A, 11/1/07; A, 11/1/12]

8.290.600.14 CHANGES IN ELIGIBILITY: If the eligible recipient ceases to meet any of the eligibility criteria, the case is closed following provision of advance notice as appropriate. See 8.200.430.9 NMAC and following subsections for information about notices and hearing rights.

A. **Non-provision of waiver services:** To continue to be eligible for waiver services, an [~~applicant/recipient~~] eligible recipient must be receiving waiver services, [~~EPSDT or salud~~] early and periodic screening, diagnostic and treatment (EPSDT) benefits or managed care services, other than case management, [42 CFR Section 435.217]. If at any time waiver services are no longer being provided (e.g., a suspension) and are not expected to be provided for 60 consecutive days, the recipient is **ineligible** for the waiver category and the case must be closed after appropriate notice is provided by the ISD [~~worker~~] caseworker.

B. **Admission to a hospital, nursing facility, or intermediate care facility for [~~the mentally retarded (ICF-MR)~~] individuals with intellectual disabilities (ICF-IDD):** If [~~a~~] an eligible waiver recipient enters an acute care hospital, a nursing facility, or an [~~ICF-MR~~] ICF-IID and remains for more than 60 consecutive days, the waiver case must be closed and an application for institutional care medicaid (ICM) must be processed. The eligible recipient is not required to complete a new application if the periodic review on the waiver case is not due in either the month of entry into the institution or the following month. If the waiver recipient is institutionalized within less than 60 consecutive days and still receives waiver services within that time frame, the waiver case is not closed and an application for [~~institutional care medicaid~~] ICM need not be processed.

C. **Reporting changes in circumstances:** The primary responsibility for reporting changes in the eligible recipient's circumstances rests with the eligible recipient or his/her representative. At the initial eligibility determination and all on-going eligibility redeterminations, the ISD [~~worker~~] caseworker must explain the reporting responsibilities requirement to the [~~applicant/recipient and~~] eligible recipient or his/her representative and document that such explanation was given. In the event that waiver services cease to be provided, the case manager or the waiver program manager (or designee) must immediately notify the income support division office of that fact by telephone. The telephone call is to be followed by a written notice to the ISD [~~worker~~] caseworker.

[2/1/95; 1/1/97; 8.290.600.14 NMAC - Rn, 8 NMAC 4.WAV.630 & A, 5/1/02; A, 11/1/07; A, 11/1/12]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.307.1 NMAC, Sections 1, 3 and 6-8, effective October 15, 2012.

8.307.1.1 ISSUING AGENCY: Human Services Department (HSD)

[8.307.1.1 NMAC - N, 8-1-08; A, 10-15-12]

8.307.1.3 STATUTORY AUTHORITY: [~~The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.~~] The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Chapter 27, Public Assistance.

[8.307.1.3 NMAC - N, 8-1-08; A, 10-15-12]

8.307.1.6 OBJECTIVE: [~~The objective of these rules is to provide policies for the service portion of the New Mexico medicaid coordination of long-term services program.~~] The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.

[8.307.1.6 NMAC - N, 8-1-08; A, 9-1-09; A, 10-15-12]

8.307.1.7 DEFINITIONS: The state of New Mexico is committed to improving the health status of New Mexico residents whose health care services are funded by the Title XIX (medicaid) program. As a means of improving health status, a coordination of long-term services program has been implemented. This section contains the glossary for the New Mexico [~~medicaid~~] medical assistance division (MAD) coordination of long-term services policy. The following definitions apply to terms used in this chapter.

A. Definitions beginning with letter "A":

(1) **Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to [~~medicaid, or the interagency behavioral health purchasing collaborative (the collaborative),~~] MAD funded programs in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes client or member practices that result in unnecessary costs to [~~medicaid or the collaborative~~] MAD.

(2) **Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

(3) **Activities of daily living:** Activities necessary for daily living, including eating, dressing, oral hygiene, bathing, mobility, toileting, grooming, taking medications, transferring from a bed or chair, and walking, consistent with NMSA 1978 Section 28-17-3

(4) **Advance directive:** Written instructions relating to the provision of health services when an adult is incapacitated[~~. May~~] and may include an advance directive, mental health advance directive, living will, durable health care power of attorney, durable mental health care power of attorney, or advance health directive.

(5) **Adverse determination:** A determination by [~~coordination of long-term services~~] a managed care organization [~~(CoLTS MCO)/single statewide entity (SE),~~] (MCO) or by its utilization review agent, that the health care services furnished or proposed to be furnished to [~~a member~~] an eligible recipient are not medically necessary or are not appropriate.

(6) **ALTSD:** The New Mexico aging and long-term services department.

(7) [~~**Appeal, member:** A request from a member or provider, on the a member's behalf with the a member's written permission, for review by the coordination of long-term services managed care organization (CoLTS MCO) or the single statewide entity (SE) for behavioral health of a CoLTS MCO/SE action as defined above in Paragraph (2) of Subsection A of 8.307.1.7 NMAC, *action*.~~] **Appeal, eligible recipient:** A request from an eligible recipient or provider, on an eligible recipient's behalf with an eligible recipient's written permission, for review by the MCO. See 8.307.1 NMAC *General Provisions* for the definition of "action".

(8) **Appeal, provider:** A request by a provider for a review by [~~a CoLTS MCO/SE of a CoLTS MCO/SE~~] the MCO's or SE's action related to the denial of payment or an administrative denial.

(9) **Approvals:** Approvals are either initial or concurrent review decisions, which yield utilization management authorizations based on the [~~client~~] eligible recipient meeting the clinical criteria for the requested [~~medicaid~~] MAD service(s) or level of care.

(10) **Assignment algorithm:** Predetermined method for assigning mandatory enrollees who do not select [~~a CoLTS~~] an MCO.

(11) **Assisted living services:** Residential services that include personal support services, companion services, and assistance with medication administration, as set forth in department of health (DOH) rules 7.8.2 NMAC, *Residential Health Facilities* or its successor.

(12) **At risk:** [~~The period of time that a member is enrolled with a CoLTS MCO/SE, during which the CoLTS MCO/SE is responsible for providing covered services under capitation.~~] The period of time that an eligible recipient is enrolled with a MCO or a SE during which the MCO is responsible for providing covered services under capitation.

B. Definitions beginning with letter "B":

(1) **Begin date:** [~~The first day of the first full month following selection of or assignment to a CoLTS MCO/SE. For members who are in a nursing facility prior to the level of care determination but not enrolled in medicaid or medicare managed care, the begin date will be the first of the month in which both nursing facility level of care and medicaid eligibility exists.~~] The first day of the first full month following selection or assignment to a MCO. For an eligible recipient resident of a nursing facility (NF) prior to the level of care (LOC) determination, but not enrolled in a MAD MCO or a medicare advantage plan, the begin date will be the first month in which both the NF LOC determination and MAD eligibility exists.

(2) **Behavioral health:** [~~Refers to mental health and substance abuse.~~] A term used that includes mental health or substance abuse.

(3) **Behavioral health planning council (BHPC):** Refers to the council created by HB 271 to meet federal advisory council requirements and to provide consistent, coordinated input to behavioral health service delivery in New Mexico. The SE will be expected to interact with the BHPC as an advisory council.

(4) **Behavioral health purchasing collaborative:** Refers to the interagency behavioral health purchasing collaborative pursuant to the passage of HB 271, effective May 19, 2004. The collaborative is made up of 17 publicly funded statutory member agencies, including eight agencies that provide and fund direct services, including the human services department.

(5) **Benefit package:** [~~Medicaid~~] MAD covered services that must be furnished by the [~~CoLTS MCO/SE~~] MCO, and for which payment is included in the capitation rate.

C. Definitions beginning with letter "C":

(1) **Capitation:** A per-member, monthly payment to a [~~CoLTS MCO~~] MCO that covers contracted services and is paid in advance of service delivery. A set amount of money received or paid out, based on membership rather than on services delivered. It is usually expressed as "per member per month" (PM/PM).

(2) **Case:** A household that [~~medicaid~~] HSD treats as a unit for purposes of eligibility determination; for example, a parent and child; a legal guardian and child; or a set of siblings.

(3) **Case management for physical health:** The [~~targeted~~] case management programs that are part of the [~~medicaid~~] MAD benefit package. [~~Targeted~~] Case management programs [~~will continue to be~~] are important service components. In these programs, case managers typically function independently and assess [~~a member's/family's~~] an eligible recipient's or his or her family's needs and strengths; develop a service/treatment plan; and coordinate, advocate for and link [~~members~~] an eligible recipient to all needed services related to the [~~targeted~~] case management program.

(4) **Claim:** A bill for services, a line item of service, or all services for one [~~member~~] eligible recipient within a bill.

(5) **Claim dispute:** A dispute, filed by a [~~CoLTS MCO or a~~] MCO or SE service provider, involving payment of a claim, denial of a claim, or imposition of a sanction.

(6) **Clean claim:** A manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside the health plan's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim is not materially deficient or improper, such as lacking substantiating documentation currently required by the health plan, or has no particular or unusual circumstances requiring special treatment that prevents payment from being made by the health plan within 30 calendar days of the date of receipt if submitted electronically or 45 calendar days if submitted manually.

[~~(7) **Client:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "client" may also be referred to as a "member", "customer", or "consumer".~~

~~(8) **CoLTS MCO/SE:** The use of CoLTS MCO/SE in these coordinated long-term services rules indicates the following rule applies to both the CoLTS MCO and the SE, who must each comply with the rule independent of each other.~~].

(7) **CoLTS:** The medical assistance division's coordination of long-term services program.

[~~(9)~~] (8) **CMS:** Centers for medicare and medicaid services.

[~~(10)~~] (9) **Community-based care:** A system of care that seeks to provide services to the greatest extent possible in or near the [~~member's~~] eligible recipient's home community.

[~~(11)~~] (10) **Complaint:** An expression of dissatisfaction expressed by a complainant, orally or in writing, to the

[~~CoLTS MCO/SE~~] MCO, SE or to HSD or its designee about any matter related to the [~~CoLTS MCO/SE~~] MCO or SE other than an action. Possible subjects for complaints include, but are not limited to, the quality of care or services provided; aspects of interpersonal relationships, such as rudeness of a service provider or employee; or failure to respect [~~a member's~~] an eligible recipient's rights.

[~~(12) **Comprehensive community support services (CCSS):** These services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community.~~

~~(13)~~] (11) **Concurrent review:** A process of updating clinical information from a service provider to a [~~CoLTS MCO/SE~~] MCO or SE regarding [~~a member~~] an eligible recipient who is already receiving a covered service, to evaluate whether the service continues to be medically necessary.

[~~(14) **Consumer:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "consumer" may also be referred to as a "member", "customer", "consumer", "participant", "client", or "recipient".~~

~~(15) **Member direction:** The ability of a member to be actively involved in and in control of, to the extent possible, all aspects of the member's individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.~~

~~(16)~~] (12) **Continuous quality improvement (CQI):** CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modifications of improvements, as indicated.

[~~(17)~~] (13) **Coordination of long-term services:** A coordinated program of physical health and community-based supports and services implemented under the authority of concurrent section 1915(b) and section 1915(c) waivers.

[~~(18)~~] (14) **Copayment:** A monetary amount specified by the state that the [~~member~~] eligible recipient pays directly to [~~the CoLTS MCO/SE~~] a MCO, SE or to a service provider at the time that covered services are rendered.

[~~(19)~~] (15) **Critical incident:** A reportable incident involving an eligible recipient that may include, but is not limited to, abuse, neglect or exploitation; death; environmental hazards; law enforcement intervention; or emergency services, and which encompasses the full range of physical health, [~~medicaid~~] MAD state plan, and home and community-based services.

[~~(20)~~] (16) **Cultural competence:** A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match an individual's culture to increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which a [~~CoLTS MCO/SE~~] MCO or SE gives another entity the authority to perform certain functions on its behalf. The [~~CoLTS MCO/SE~~] MCO or SE retains full accountability for the delegated functions.

(2) **Denial, administrative/technical:** [~~A denial of authorization requests due to the requested procedure, service or item not being covered by medicaid, not being on the CoLTS MCO/SE formulary or due to provider noncompliance with administrative policies and procedures established by either the CoLTS MCO/SE or the medical assistance division.~~] A denial of authorization requests due to the requested procedure, service or item not being covered by MAD, or due to provider noncompliance with administrative policies and procedures established by either the MCO or SE or MAD.

(3) **Denial, clinical:** A non-authorization decision at the time of an initial request for a medicaid service or a formulary exception request based on the [~~member~~] eligible recipient not meeting medical necessity for the requested service. The utilization management (UM) staff may recommend an alternative service, based on the [~~client's~~] eligible recipient's need for a lower [~~level of service~~] LOC. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

(4) **Disease management plan:** A comprehensive plan following nationally recognized components for chronic disease interventions including population identification/stratification processes, collaborative practice models, patient self-management education processes, evidence-based practice guidelines, process and outcome measurements, and internal quality improvement processes.

(5) [~~**Disenrollment, CoLTS MCO initiated:** When requested by a CoLTS MCO for substantial reason, removal of a medicaid member from membership in the requesting CoLTS MCO, as determined by HSD, on a case-by-case basis.~~] **Disenrollment, MCO initiated:** When requested by a MCO for substantial reason, removal of an eligible recipient from membership in the requesting MCO, as determined by HSD, on a case-by-case basis.

(6) [~~**Disenrollment, member initiated (switch):** When requested by a member for substantial reason, transfer of a medicaid member as determined by HSD on a case-by-case basis, from one CoLTS MCO to a different CoLTS MCO during a member lock-in period.~~] **Disenrollment, eligible recipient initiated (switch):** When requested by an eligible recipient for substantial reason, transfer of an eligible recipient as determined by HSD on a case-by-case basis, from one MCO to a different MCO during a member lock-in period.

(7) **Durable medical equipment (DME):** Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is not useful to [~~individuals~~] an eligible recipient in the absence of an illness or injury, and is appropriate for use at home.

E. Definitions beginning with letter "E":

(1) **Eligible recipient:** An individual who has been determined eligible for enrollment in a medical assistance program.

[~~(1)~~] (2) **Emergency:** An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

[~~(2) **Encounter:** The record of a physical or behavioral health service rendered by a provider to a CoLTS MCO/SE member, client, customer, or consumer.~~]

(3) **Encounter:** The record of a service rendered by a provider to a MCO or SE eligible recipient.

[~~(3)~~] (4) **Encounter data:** Data elements from encounters for fee-for-service or capitated service proxy claims. Encounter data elements are a combination of those elements required by HIPAA-compliant transaction formats and other data elements that comprise a [~~minimum core~~] data set.

[~~(4) **Enrollee:** A medicaid participant who is currently enrolled in a CoLTS MCO/SE coordinated long-term services program.~~

~~(5) **Enrollee rights**: Rights that each coordination of long-term services enrollee is guaranteed.~~]

(5) **Eligible recipient rights:** Rights guaranteed by his or her MCO or SE.

(6) **Eligible recipient direction:** The ability of an eligible recipient to be actively involved in and in control of, to the extent possible, all aspects of the eligible recipient's individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.

(7) **Enhanced service:** Any service or benefit offered by the MCO or SE that is not included in the MAD benefit package or otherwise required by MAD and is not a MAD funded service, benefit or entitlement under the New Mexico Public Assistance Act. Also referred to as value added services.

[~~(6)~~] (8) **Enrollment:** The process of enrolling [~~eligible clients~~] an eligible recipient in a [~~CoLTS MCO/SE~~] MCO or SE for purposes of management and coordination of health service delivery.

[~~(7)~~] (9) **EPSDT:** Early and periodic screening, diagnostic and treatment.

[~~(8)~~] (10) **Exemption:** Removal of [~~a medicaid member~~] an eligible recipient from mandatory enrollment in coordination of long-term services, and placement in the [~~medicaid~~] MAD fee-for-service (FFS) program. Such action is only for substantial reason, as determined by HSD on a case-by-case basis.

[~~(9)~~] (11) **Expedited appeal:** A federally mandated provision for an expedited resolution within three working days of the requested appeal, which includes an expedited review by the [~~CoLTS MCO/SE of a CoLTS MCO/SE~~] MCO or SE action.

[~~(10)~~] (12) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise capable of reviewing the evidence of compliance of health care delivery and internal quality assurance/improvement requirements.

F. Definitions beginning with letter "F":

(1) **Family-centered care:** When the child is the patient, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and medical professionals, builds on individual and family strengths, and respects diversity of families.

(2) **Family planning services:** Services provided to [~~members~~] male or female eligible recipients of childbearing age to temporarily or permanently prevent or delay pregnancy (see 8.325.3 NMAC [~~MAD 762~~], *Reproductive Health Services*).

(3) **Fee-for-service (FFS):** The traditional medicaid payment method whereby payment is made by HSD to a service provider after services are rendered and billed.

(4) **Federally qualified health center (FQHC):** An entity that meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC may include an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638), or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

(5) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, a [~~CoLTS MCO/SE~~] MCO or SE, subcontractor, provider, or [~~client,~~] eligible recipient with the knowledge that the deception could result in some unauthorized benefit to himself or to some other previously described entity or person. It includes any act that constitutes fraud under applicable federal or state law.

(6) **Full benefit dual eligible:** [~~An individual enrolled in medicare and eligible for full medicaid benefits, not limited to covering costs, such as medicare premiums.~~] An individual enrolled in medicare and also is eligible for full MAD benefits.

(7) **Full risk contracts:** Contracts that place [~~the CoLTS MCO/SE~~] a MCO or SE at risk for furnishing or arranging for comprehensive services.

G. Definitions beginning with letter "G":

(1) **Gag order:** Subcontract provisions or [~~CoLTS MCO/SE~~] MCO or SE practices, either written, oral or implied, that effectively prevent a provider from furnishing accurate or complete information to [~~members~~] an eligible recipient about options for diagnosis or treatment of physical, mental or behavioral illness, injury, or condition; or prevent a provider from talking to the [~~member~~] eligible recipient or HSD about the [~~CoLTS MCO/SE~~] MCO or SE or [~~its~~] their business practices.

(2) [~~**Grievance, member:** An oral or written statement by a member recipient expressing dissatisfaction with any aspect of a CoLTS MCO/SE or its operations that is not a CoLTS MCO/SE action.~~] **Grievance, eligible recipient:** An oral or written statement by an eligible recipient expressing dissatisfaction with any aspect of a MCO or its operations but does not met the definition of "action" or "adverse determination".

(3) **Grievance, provider:** An oral or written statement by a provider to the CoLTS MCO/SE expressing dissatisfaction with any aspect of a [~~CoLTS MCO/SE or its operations that is not a CoLTS MCO/SE action~~] MCO, SE or their operations but does not meet the definition of "action" or "adverse determination".

(3) **Grievance, provider:** An oral or written statement by a provider to [~~the CoLTS MCO/SE~~] a MCO expressing dissatisfaction with any aspect of a [~~CoLTS MCO/SE or its operations that is not a CoLTS MCO/SE action~~] MCO, SE or MCO or SE or their operations but does not meet the definition of "action" or "adverse determination".

H. Definitions beginning with letter "H":

(1) **HCFA:** Health care financing administration. Effective 2001, the name was changed to centers for medicare and medicaid services (CMS).

(2) **Health plan:** A health maintenance organization (HMO), managed care organization (MCO), prepaid inpatient health plan (PIHP), or third party payer or their agents.

(3) **Hearing or fair hearing:** An administrative hearing that is held so that evidence may be presented. (See 8.352.2 NMAC, *Recipient Hearings*.)

(4) **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

(5) **Hospitalist:** A physician employed by a hospital to manage the services of [~~a member~~] an eligible recipient admitted to the hospital for inpatient services.

(6) **Human services department (HSD):** The sole executive department in New Mexico responsible for the administration of Title XIX (medicaid). "HSD" may also indicate the department's designee, as applicable.

I. Definitions beginning with letter "I":

(1) **IBNR (claims incurred but not reported):** Claims for services authorized or rendered for which the [~~CoLTS MCO/SE~~] MCO or SE has incurred financial liability, but the claim has not been received by [~~the CoLTS MCO/SE~~] a MCO or SE. This estimating method relies on data from prior authorization and referral systems, other data analysis systems and accepted accounting practices.

(2) **Individualized service plan (ISP):** An individualized service plan developed with and for [~~members who have~~] an eligible recipient who has chronic or complex conditions, and with others involved in the [~~member's~~] eligible recipient's services, to improve functional outcomes, including the standards in [~~8.314.2.15 NMAC, *individualized service plan*~~] 8.314.2 NMAC, *Disabled and Elderly Home and Community Based Waiver*. An ISP includes, but is not limited to: [~~a~~

~~member's~~] an eligible recipient's history; a summary of current medical and social needs and concerns; short and long-term service needs and goals; a list of services required and their frequency; and a description of who will provide the services. An ISP must be in accordance with the approved CMS coordination of long-term services home and community-based waiver program and New Mexico [~~medicaid~~] MAD state plan.

(3) **Individuals with special health care needs (ISHCN):** Individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or have low to severe functional limitation and who also require health and related services of a type or amount beyond that required by individuals generally.

J - K. [RESERVED]

L. Definitions beginning with letter "L": **Long-term services:** A continuum of services and supports for eligible recipients, ranging from in-home and community-based services for the elderly and [~~individuals~~] eligible recipients with disabilities who need help in maintaining their independence, to institutional services for those who require an institutional level of support. Throughout the continuum of long-term services and supports, the goal is to provide needed services and supports to the [~~member~~] eligible recipient while striving to maintain the [~~member's~~] eligible recipient's independence to the greatest extent possible.

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** [~~An organization licensed to manage, coordinate and assume financial risk on a capitated basis for the delivery of specified services to enrolled members from a certain geographic area. Also referred to as a managed care plan and managed care program.~~] A contracted organization licensed to manage, coordinate and assume financial risk on a capitated basis for the delivery of specified services to an enrolled eligible recipient. The MCO may be contracted specifically to provide physical health services to an eligible recipient entolled in CoLTS as a CoLTS MCO or for behavioral health services as the single entity (SE) contracted to provide behavioral health services to an eligible recipient enrolled in CoLTS. A CoLTS MCO and the SE must each comply with the rules independently of each other.

(2) **Marketing:** The act or process of promoting a business or commodity. Marketing materials include brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, yellow page advertisements, and any other presentation materials used by a [~~CoLTS MCO/SE, CoLTS MCO/SE representative, or CoLTS MCO/SE subcontractor to attract or retain medicaid enrollment~~] MCO or SE, MCO or SE representative or MCO or SE subcontractor to attract or retain MAD enrollment.

(3) **Medicaid:** The medical assistance program authorized under Title XIX of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

(4) **Medical/clinical home:** A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

(5) **Medically necessary services:**

(a) Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the [~~individual~~] eligible recipient to attain, maintain or regain functional capacity;

(ii) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the [~~individual~~] eligible recipient;

(iii) are provided within professionally accepted standards of practice and national guidelines; and

(iv) are required to meet the physical and behavioral health needs of the [~~individual~~] eligible recipient and are not primarily for the convenience of the [~~individual~~] eligible recipient, the provider or the payer.

(b) Application of the definition:

(i) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit;

(ii) the [~~CoLTS MCO/SE~~] MCO or SE making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the [~~medicaid~~] MAD benefit package applicable to an eligible individual shall do so by; 1) evaluating individual physical and behavioral health information provided by qualified professionals who have personally evaluated the [~~individual~~] eligible recipient within their scope of practice, who have taken into consideration the [~~individual's~~] eligible recipient's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate; 2) considering the views and choices of the [~~individual or the individual's~~] eligible recipient or his or her legal guardian, agent, representative or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and 3) considering the services being provided concurrently by other service delivery systems;

(iii) physical and behavioral health services shall not be denied solely because the [~~individual~~] eligible recipient has a poor prognosis; required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible [~~individual~~] recipient solely because of the diagnosis, type of illness or condition; and

(iv) decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

(6) [~~**Member:** A client enrolled in a CoLTS MCO/SE.~~] **Member or eligible recipient direction:** The ability of an eligible recipient to be actively involved in and in control of, to the extent possible, all aspects of his or her individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.

(7) **Member month:** A calendar month during which [~~a member~~] an eligible recipient is enrolled in a [~~CoLTS MCO/SE~~] MCO or SE.

(8) **Mi via home and community-based waiver:** The mi via waiver provides self-directed home and community based services (HCBS) to eligible HCBS waiver recipients who are disabled or elderly (D&E) now CoLTS (c), developmentally disabled (DD), medically fragile (MF), those diagnosed with acquired immunodeficiency syndrome (AIDS), and those diagnosed with certain brain injuries (BI).

N. Definitions beginning with letter "N":

(1) **National committee for quality assurance (NCQA):** A private national organization that develops quality standards for managed health care.

(2) **Network provider:** An individual provider, clinic, group, association or facility employed by or contracted with a [~~CoLTS MCO/SE~~] MCO or SE to furnish medical [~~or behavioral health~~] services to [~~CoLTS MCO/SE members~~] an eligible recipient enrolled in a MCO or SE under the provisions of the [~~medicaid coordination of long-term services~~] MAD CoLTS or SE contract.

(3) **Non-contracted provider (non-network provider):** An individual service provider, clinic, group, association or facility that provides covered services but does not have a contract with the [~~CoLTS MCO/SE~~] MCO.

(4) **Nursing facility:** A [~~medicare/medicaid~~] medicare/MAD facility licensed and certified in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to [~~members~~] an eligible recipient

who require these services on a continuous basis but who do not require hospital services or direct daily services from a physician.

O. [RESERVED]

P. Definitions beginning with letter "P":

[~~(1) **Participant:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "participant" may also be referred to as a "member", "customer", "consumer", "client", or "recipient".~~]

[~~(2)~~] (1) **Pend decision:** A prior authorization decision is considered pended when the decision is delayed due to lack of documentation, inability to contact parties involved or other reason which delays finalizing an approval. A decision by a [~~CoLTS MCO/SE~~] MCO or SE to pend approval does not extend or modify required utilization management decision timelines.

[~~(3)~~] (2) **Performance improvement project (PIP):** A [~~CoLTS MCO/SE~~] MCO or SE QM program activity must include projects that are designed to achieve significant improvement in clinical or non-clinical care areas. PIPs must involve measurements using objective quality indicators, system intervention to achieve improvement, evaluation of the effectiveness of interventions, and activities for increasing or sustaining improvement. Outcomes must be measurable over a period of time.

[~~(4)~~] (3) **Performance measurement (PM):** Data specified by the state that enables the [~~CoLTS MCO/SE~~] MCO or SE performance to be determined.

[~~(5)~~] (4) **Person-centered planning:** A process through which each [~~consumer or participant~~] eligible recipient is actively engaged, to the extent that the [~~consumer or participant~~] eligible recipient desires, in identifying their needs, goals and preferences, and in developing strategies to address those needs, goals and preferences.

[~~(6)~~] (5) **Plan of care:** A written document including all medically necessary services to be provided by [~~the CoLTS MCO/SE~~] a MCO or SE for a specific [~~member~~] eligible recipient.

[~~(7)~~] (6) **Policy:** The statement or description of requirements.

[~~(8)~~] (7) **Post-stabilization care services:** Services related to an emergency medical condition that are provided after [~~a member~~] an eligible recipient is medically stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR Section 438.114(b) and (e) and 42 CFR Section 422.113(c)(iii) to improve or resolve the [~~member's~~] eligible recipient's condition.

[~~(9)~~] (8) [~~**Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given coordination of long-term services program, but is not yet a member of a specific CoLTS MCO/SE.~~] **Potential MCO or SE eligible recipient:** An eligible recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given CoLTS program but is not enrolled in a specific MCO or the SE.

[~~(10)~~] (9) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

[~~(11)~~] (10) **Preventive health services:** Services that follow current national standards for prevention including both physical and behavioral health.

[~~(12)~~] (11) **Primary care:** All health services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant or certified nurse practitioner.

[~~(13)~~] (12) **Primary care case management (PCCM):** A medical care model in which [~~clients are~~] an eligible recipient is assigned to a primary care provider who is responsible for managing the quality, appropriateness, and efficiency of the care [~~they receive~~] the eligible recipient receives. The primary care provider is responsible for furnishing case management services to [~~medicaid eligible recipients~~] an eligible recipient that include the location, coordination, and monitoring of primary health care services and the appropriate referral to specialty care services.

[~~(14)~~] (13) **Primary care case manager:** A physician, a physician group practice, an entity that [~~medicaid-eligible recipients employ or arrange~~] an eligible recipient employs or arranges with physicians to furnish primary care case management services or, at state option, any of the following:

(a) a physician assistant;

(b) a nurse practitioner; or

(c) a certified nurse midwife.

[~~(15)~~] (14) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to [~~members in the coordination of long-term services~~] an eligible recipient in a CoLTS program.

[~~(16)~~] (15) **Procedure:** Process required to implement a policy.

[~~(17)~~] (16) **Provider lock-in, PCP lock-in:** A situation in which [~~the CoLTS MCO/SE~~] a MCO or SE requires that [~~a member see~~] an eligible recipient see a specific identified network provider, while ensuring reasonable access to additional services, when the [~~CoLTS MCO/SE~~] MCO or SE identifies utilization of unnecessary services or when [~~a member's~~] an eligible recipient's behavior is detrimental or indicates a need to provide case continuity.

Q. Definitions beginning with letter "Q": **Quality assurance:** A process that is adopted by a health services entity that follows written standards and criteria. The process includes the activities of a health services entity or any of its committees that: investigate the quality of health services through the review of professional practices, home and community-based service provider practices, training and experience; investigate patient cases or conduct of licensed health service providers; or encourage proper utilization of health care services and facilities. Quality assurance follows a process of discovery, both prospective and retrospective to evaluate the program; identifies areas for remediation; and implements quality improvement strategies to ensure that appropriate and timely action is taken, as indicated.

R. Definitions beginning with letter "R":

(1) **Rate cell:** A combination of category of eligibility and demographics used to isolate utilization patterns for the determination of capitation.

(2) **Received but unpaid claims (RBUC):** Claims received by the [~~CoLTS MCO/SE~~] MCO or SE but not paid, affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the [~~CoLTS MCO/SE~~] MCO or SE.

(3) **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service than were originally requested. The authorization is based on the [~~client's~~] eligible recipient's physical health (medical needs) or behavioral health (clinical needs) or long-term services needs.

(4) **Referral:** Any specialty, inpatient, outpatient, or diagnostic services that a physician or physician group orders or arranges, but does not provide directly.

(5) **Reinsurance:** Reinsurance is a proactive financial tool that may be used by a [~~CoLTS MCO/SE~~] MCO or SE to minimize exposure to losses incurred when members utilize health care services beyond anticipated levels or overall member utilization is greater than expected.

(6) **Risk:** The possibility that revenues of a [~~CoLTS MCO/SE~~] MCO or SE will not be sufficient to cover expenditures incurred in the delivery of contractual services.

(7) **Routine care:** All care that is not emergent or urgent.

S. Definitions beginning with letter "S":

(1) **Salud!:** The New Mexico physical health managed care program implemented in 1997, covering children, families, pregnant women and disabled New Mexicans. [~~Parents of medicaid-eligible children were also covered by medicaid if they met eligibility requirements.~~]

(2) S**ervice coordination:** A specialized service management that is performed by a service coordinator, in collaboration with [~~the member or the member's family or representatives~~] an eligible recipient or the eligible recipient's family member or a representative as appropriate, that is person-centered, and that includes, but is not limited to: (a) identification of the [~~member's~~] eligible recipient's needs, including physical health services, mental health services, social services, and long-term support services; and development of the [~~member's~~] eligible recipient's ISP or treatment plan to address those needs; (b) assistance to ensure timely and coordinated access to an array of providers and services; (c) attention to addressing unique needs of [~~members~~] an eligible recipient; and (d) coordination with other services delivered outside the ISP, as necessary and appropriate. Service coordination operates independently within the [~~CoLTS MCO/SE~~] MCO or SE using recognized professional standards adopted by the [~~CoLTS MCO/SE~~] MCO or SE and approved by the state, based on the service coordinator's independent judgment to support the needs of the [~~member~~] eligible recipient and is structurally linked to the other [~~CoLTS MCO/SE~~] MCO or SE systems, such as quality assurance, [~~member~~] eligible recipient services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations.

(3) **Service coordinator:** An employee or subcontractor of [~~the CoLTS MCO/SE~~] a MCO or SE with primary responsibility for providing service coordination/management to [~~members who have~~] an eligible recipient who has complex care needs including long-term service and supports or needs, or who otherwise [~~want~~] wants assistance with service planning. The service coordinator need not be a medical professional.

(4) **Single statewide entity (SE):** The entity selected by the state of New Mexico through the behavioral health collaborative to perform all contract functions defined in the behavioral health request for proposals (RFP). The SE is a single contractor selected to provide all defined service responsibilities statewide, including medicaid behavioral health benefits. The SE will administer both the medicaid managed care and medicaid fee-for-service (FFS) programs for all [~~medicaid~~] MAD behavioral health services. The SE [~~shall be~~] is responsible for contracting with providers, paying provider claims, assuring care coordination, conducting utilization review and utilization management activities, assuring quality review and service delivery improvement, credentialing practitioners and provider agencies, privileging practitioners to deliver critical services or service approaches, evaluating and monitoring service delivery, and conducting any other administrative functions necessary to achieve the goals of the collaborative. The SE is the agent of the collaborative and shall "coordinate", "braid" or "blend" the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico.

(5) **Special needs individual:** A medicare advantage (MA) eligible individual who is institutionalized, is entitled to medical assistance under a state plan under Title XIX, or has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized MA plan.

(6) **Special needs plan:** A specialized MA coordinated service plan for special needs individuals that exclusively or disproportionately serves special needs individuals.

(7) **State plan:** A statewide plan for [~~medicaid~~] MAD eligibility and services submitted for approval to CMS under Title XIX of the federal Social Security Act.

(8) **Subcontract:** A written agreement between a [~~CoLTS MCO/SE~~] MCO or SE and a third party, or between a subcontractor and another subcontractor, to provide services.

(9) **Subcontractor:** A third party who contracts with a [~~CoLTS MCO/SE~~] MCO or SE or a [~~CoLTS MCO/SE~~] MCO or SE subcontractor for the provision of services.

(10) **Suspension or suspended provider:** A service provider that has been convicted of a program-related offense in a federal, state or local court. Items or services furnished by a suspended provider will not be reimbursed under [~~medicaid~~] MAD.

T. Definitions beginning with letter "T":

(1) **Terminations of care:** The utilization management review decision made during a concurrent review that yields a denial based on the current service being no longer medically necessary.

(2) **Third party:** An individual entity or program that is or may be, liable to pay all or part of the expenditures for [~~medicaid members for services furnished under a state plan~~] an eligible recipient's services.

(3) **Tribal facility 638:** A facility operated by a Native American or Indian tribe authorized to provide services pursuant to the Indian Self-Determination and Education Assistance Act.

(4) **Tribal provider or Indian health service (IHS) provider:** A facility that is operated by a Native American/ Alaskan Indian tribe authorized to provide services as defined in the Health Care Improvement Act, 25 USC Section 1601, et seq.

U. Definitions beginning with letter "U":

(1) **Urgent condition:** Acute signs and symptoms that, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

(2) **Utilization management:** A system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a member.

V. [~~Definitions beginning with letter "V": **Value-added service:** Any service or benefit offered by the CoLTS MCO/SE that is not included in the coordination of long-term services benefit package and is not a medicaid funded service, benefit or entitlement under the New Mexico Public Assistance Act.~~] [RESERVED]

W. Definitions beginning with letter "W": **Waiver program:** One or more of the state of New Mexico [~~medicaid~~] MAD home and community-based services waiver programs.

X - Z. [RESERVED]

[8.307.1.7 NMAC - N, 8-1-08; A, 9-1-09; A, 10-15-12]

8.307.1.8 M I S S I O N STATEMENT: [~~The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.~~] To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.307.1.8 NMAC - N, 8-1-08; A, 9-1-09; A, 10-15-12]

NEW MEXICO LIVESTOCK BOARD

TITLE 21 AGRICULTURE AND RANCHING
CHAPTER 30 ANIMALS AND ANIMAL INDUSTRY GENERAL PROVISIONS
PART 9 FERAL HOGS

21.30.9.1 ISSUING AGENCY: New Mexico Livestock Board.
[21.30.9.1 NMAC - N, 10/15/2012]

21.30.9.2 SCOPE: Applicable to entities and persons.
[21.30.9.2 NMAC - N, 10/15/2012]

21.30.9.3 S T A T U T O R Y AUTHORITY: Sections 77-2-1, 77-2-7 and 77-18-6 NMSA 1978.

[21.30.9.3 NMAC - N, 10/15/2012]

21.30.9.4 DURATION: Permanent.
[21.30.9.4 NMAC - N, 10/15/2012]

21.30.9.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.
[21.30.9.5 NMAC - N, 10/15/2012]

21.30.9.6 OBJECTIVE: To clarify the meaning of livestock and the regulatory authority of the New Mexico livestock board as it pertains to feral hogs.
[21.30.9.6 NMAC - N, 10/15/2012]

21.30.9.7 DEFINITIONS: [RESERVED]

21.30.9.8 FERAL HOGS:

A. Section 77-18-6 NMSA 1978, pertaining to feral hogs, was enacted to protect the public health, welfare and safety and to prevent the introduction and spread of disease. That statute prohibits certain conduct as described in that section as it pertains to feral hogs.

B. Feral hogs are considered vermin, incompatible with the environment, and are noxious, pestilent, predatory, foreign and invasive, offensive and injurious to man and his domesticated animals, and are not considered livestock to be regulated under the New Mexico Livestock Code, and, as such, are not protected against removal, destruction or elimination.
[21.30.9.8 NMAC - N, 10/15/2012]

HISTORY OF 21.30.9 NMAC: [RESERVED]

NEW MEXICO LIVESTOCK BOARD

This is an amendment to 21.32.3 NMAC, Sections 1, 3 and 8, effective 10/15/2012.

21.32.3.1 ISSUING AGENCY: New Mexico Livestock Board[, ~~300 San Mateo, NE, Suite 1000; Albuquerque, New Mexico 87108; telephone: (505) 841-6161~~].
[21.32.3.1 NMAC - Rp, 21 NMAC 32.3.1, 5/28/2004; A, 10/15/2012]

21.32.3.3 STATUTORY AUTHORITY: Section 77-2-7, A. 6, 7, 8, 9, & 12, G, Section 77-3-1, 77-9-28, 77-9-30, 77-9-31 NMSA 1978.
[21.32.3.3 NMAC - Rp, 21 NMAC 32.3.3, 5/28/2004; A, 10/15/2012]

21.32.3.8 CREATING DISTRICTS:

A. The board shall, as it deems necessary, create such districts within the state for the purpose of controlling the movement of livestock.

B. The districts shall be known as "livestock inspection districts" and will coincide with the boundaries of the districts shown on the "livestock inspection districts map" dated June 21, 1997 and available at the office of the New Mexico livestock board.

C. Upon approval of the livestock inspector in charge, livestock may move within the designated district without inspection. All livestock intended for shipment from one district to another must be inspected prior to leaving the district, unless the inspector in charge shall designate another location outside the district of origin where the livestock will be subsequently inspected.

D. "International livestock inspection zone within districts" are created, to include the exterior boundaries within the United States of facilities comprising international import receiving facilities and any board-designated holding facility that directly receives livestock that have been transported directly to an international import receiving facility and that have been inspected for health by the United States department of agriculture. As to those USDA-inspected livestock, which have been received by the international import receiving facility and any nearby private holding facility, no prior permit from the board is required in order to enter those facilities. The board's inspection and health requirements apply in order to permit livestock movement from within the boundaries of the international livestock inspection zone to beyond said zone. The board's inspection and health requirements apply in order to permit livestock movement from outside the boundaries of the international livestock inspection zone to within said zone. Evidence of compliance with all inspection and health requirements necessary to enter New Mexico must also accompany all livestock that move from the international inspection zone into New Mexico.
[21.32.3.8 NMAC - Rp, 21 NMAC 32.3.8, 5/28/2004; A, 10/15/2012]

NEW MEXICO BOARD OF PHARMACY

This is an amendment to 16.19.4 NMAC, Sections 7, 14, 16 and 17, effective 10-25-12.

16.19.4.7 DEFINITIONS:

A. "A year" begins with the first day of the pharmacist's birth month and ends the last day of the pharmacist's birth month the following year.

B. "Activity" as used in the ACPE criteria for quality and these regulations, the term refers to an individual educational experience or program such as a lecture, home study course, workshop, seminar, symposium, etc.

C. "Alternate supervising physician" means a physician who holds a current unrestricted license, is a cosignatory on the notification of supervision, agrees to act as the supervising physician in the supervising physician's absence, or expand the "scope of practice and/or sites of practice" of the pharmacist clinician and is approved by the board.

D. "Approved provider" means an institution, organization or agency that has been recognized by the accreditation council for pharmaceutical education (ACPE) as having met it's criteria indicative of the ability to provide quality continuing pharmaceutical education, and is listed in the ACPE annual publication of approved providers.

E. "Board" means the New Mexico board of pharmacy.

F. "Consultation" means communication in person, telephonically, by two-way radio, by e-mail or by other electronic means.

G. "Contract hour" means a unit of measure equivalent to sixty (60) minutes of participation in an approved organized learning experience or activity.

H. "Continuing education unit (CEU)" means ten contact hours of participation or it's equivalent in an organized continuing education activity sponsored by an approved provider.

I. "Continuing pharmacy education (CPE)" means a structured education activity offered by an approved provider, designed or intended to support the continuing development of pharmacies or pharmacy technicians to maintain and enhance their competence. Continuing pharmacy education should promote problem-solving and critical thinking and be applicable to the practice of pharmacy.

J. "Continuing professional development (CPD)" means the responsibility of individual pharmacists for systematic maintenance, development and broadening of knowledge, skills and attitudes, to ensure continuing competence as a professional, throughout their careers.

K. "Criteria for quality" means continuing education provider shall show evidence of adherence to the criteria adopted by the American council on pharmaceutical education as indicative of the ability to provide continuing pharmaceutical education activities; areas include: administrative & organization; budget & resources; teaching staff; educational content

management of activity; method of delivery; facilities; evaluation mechanism.

L. "Dangerous drug" means a drug that, because of any potentiality for harmful effect or the methods of its use or the collateral measures necessary to its use, is not safe except under the supervision of a physician licensed by law to direct the use of such drug and the drug prior to dispensing is required by federal law and state law to bear the manufacturer's legend "Caution: Federal law prohibits dispensing without a prescription".

M. "Guidelines or protocol" means a written agreement between a pharmacist clinician or group of pharmacist clinicians and a physician or group of physicians that delegates prescriptive authority.

N. "Initial pharmacist licensure" means the license issued shall be valid for no less than 24 months. The license will expire the last date of his/her birth month that immediately follows the minimum 24 month time period.

O. "Live programs" means CPE activities that provide for direct interaction between faculty and participants and may include lectures, symposia, live teleconferences, workshops, etc.

P. "Mediated forms" means learning transmitted via intermediate mechanism such as audio and/visual tape, telephonic transmission, etc.

Q. "Monitor dangerous drug therapy" means to review the dangerous drug therapy regimen of patients by a pharmacist clinician for the purpose of evaluating and rendering advice to the prescribing physician regarding adjustment of the regimen. "Monitor dangerous drug therapy" includes:

(1) collecting and reviewing patient dangerous drug histories;

(2) measuring and reviewing routine patient vital signs including pulse, temperature, blood pressure and respiration;

(3) ordering and evaluating the results of laboratory tests relating to dangerous drug therapy, including blood [~~chemestries~~] **chemistries** and cell counts, controlled substance therapy levels, blood, urine, tissue or other body fluids, culture and sensitivity tests when performed in accordance with guidelines or protocols applicable to the practice setting and;

(4) evaluating situations that require the immediate attention of the physician and instituting or modifying treatment procedures when necessary.

R. "Oversight committee" means a joint committee made up of (4) members to hear issues regarding pharmacist clinicians' prescriptive authority activities and supervising physicians' direction of these activities.

S. "Patient safety" means the prevention of healthcare errors and the elimination or mitigation of patient injury caused by healthcare errors.

T. "Pharmaceutical care" means the provision of drug therapy and other patient care services related to drug therapy intended to achieve definite outcomes that improve a patient's quality of like, including identifying potential and actual drug-related problems, resolving actual drug-related problems and preventing potential drug-related problems;

U. "Pharmacist" means a person duly licensed by the board to engage in the practice of pharmacy pursuant to the Pharmacy Act, Sections 61-11-1, 61-11-2, 61-11-4 to 61-11-28 NMSA 1978.

V. "Pharmacist clinician" means a pharmacist with additional training required by regulations adopted by the board in consultation with the New Mexico medical board and the New Mexico academy of physician assistants, who exercises prescriptive authority in accordance with guidelines or protocol.

W. "Pharmacist in charge" means a pharmacist who accepts responsibility for the operation of a pharmacy in conformance with all laws and rules pertinent to the practice of pharmacy and the distribution of drugs and who is personally in full and actual charge of the pharmacy and its personnel.

X. "Practice of pharmacy" [~~means the evaluation and implementation of a lawful order of a licensed practitioner; the dispensing of prescriptions; the participation in drug and device selection or drug administration that has been ordered by a licensed practitioner, drug regimen reviews and drug or drug-related research; the administering or "practitioner" means a physician prescribing of dangerous drug therapy; the provision of patient counseling and pharmaceutical care; the responsibility for compounding and labeling of drugs and devices; the proper and safe storage of drugs and devices; and the maintenance of proper records.~~] **means continually optimizing medication safety, patient wellness, and quality of services through the effective use of pharmaceutical care and emerging technologies and competency-based and performance-based training.**

(1) Pharmaceutical dispensing including product selection. Practice of pharmacy may include, but is not limited to:

(2) specialty pharmacy practice including pharmacists working for licensed pharmaceutical manufacturers or wholesalers;

(3) practice of telepharmacy within and across state lines;

(4) engaging in health care educational activities;

(5) pharmacy-specific academia;

(6) provision of those acts or services necessary to provide pharmaceutical care in all areas of patient care including patient counseling, prescriptive authority, drug administration, primary care, medication therapy management, collaborative practice, and monitoring dangerous drug therapy;

(7) inspecting on a full time basis to ensure compliance with the practice of pharmacy;

(8) provision of pharmaceutical and drug information services, as well as consultant pharmacy services;

(9) engaging in other phases of the pharmaceutical profession including those with research or investigational or dangerous drugs; or

(10) engaging in functions that relate directly to the administrative, advisory, or executive responsibilities pursuant to the practice of pharmacy in this state;

(11) the responsibility for compounding and labeling of drugs and devices;

(12) the proper and safe storage of drugs and devices; and

(13) the maintenance of proper records.

Y. "Practitioner" means a physician duly authorized by law in New Mexico to prescribe dangerous drugs including controlled substances in schedules II through V.

Z. "Prescriptive authority" means the authority to prescribe, administer, monitor or modify dangerous drug therapy.

AA. "Professional judgment" means a cognitive process, by alicensed pharmacist, that takes education, experience and current standards of practice into consideration when drawing conclusions and reaching decisions.

BB. "Renewal period" means continuing education programs or activities must be completed during the 24 month time period [~~occuring~~] **occurring** between the first day of the pharmacist's birth month and the last day of his/her birth month 2 years later.

CC. "Scope of practice" means those duties and limitations of duties placed upon a pharmacist clinician and/or the alternate supervising physician(s) and the board; includes the limitations implied by the field of practice of the supervising physician and/or the alternate supervising physician(s) and the board.

DD. "Supervising physician" means a doctor, or group of doctors, of medicine or osteopathy approved by the respective board to supervise a pharmacist clinician; "supervising physician includes a physician approved by the

respective board as an alternate supervising physician.
[02-15-96; 16.19.4.7 NMAC - Rn, 16 NMAC 19.4.7, 03-30-02; A, 01-31-07; A, 08-16-10; A, 10-25-12]

16.19.4.14 ACTIVE STATUS: [~~Any pharmacist substantiating an annual aggregate of eighty hours or more in the practice of pharmacy shall be issued an active license. The following individuals are exempt the 80 hour requirement:~~

~~**A.** Pharmacists who are regularly engaged in teaching, shall be those who hold a full-time position with any accredited college of pharmacy in the state.~~

~~**B.** Pharmacists who are regularly engaged in servicing, shall be those who hold full-time positions with licensed pharmaceutical manufacturers or wholesalers and whose duties require regular periodical calls upon those who are licensed to maintain or operate a pharmacy in the state.~~

~~**C.** Pharmacists who are regularly engaged in manufacturing shall be those who have full-time personal and direct supervision or responsibility in the manufacture and production of dangerous drugs or devices in this state.~~

~~**D.** Pharmacists who are regularly engaged in inspecting shall be those who are employed on a full-time basis, in this state, to insure the proper and strict compliance of laws pertaining to the practice of pharmacy and submit reports of such activity to public agencies or supervisory personnel.~~

~~**E.** Pharmacists who are regularly engaged in other phases of the pharmaceutical profession shall include those who hold full-time positions in research of investigational or dangerous drugs, or those who hold full-time positions in functions that relate directly to the administrative, advisory or executive responsibilities pursuant to the practice of pharmacy in this state.~~] **Any pharmacist who maintains competency through the development and maintenance of knowledge, skill and aptitude, to ensure continuing competence as a pharmacy professional, and is able to demonstrate to the board said competence in the practice of pharmacy shall be issued an active license. Records of continuing education or continuous professional development shall be maintained and available for inspection by the board or the board's agent. A pharmacist shall be issued an active status license upon proper application and payment of fees.**
[08-27-90; 16.19.4.14 NMAC - Rn, 16 NMAC 19.4.14, 03-30-02; A, 12-15-02; A, 10-25-12]

16.19.4.16 RESPONSIBILITIES OF PHARMACIST AND PHARMACIST INTERN:

A. The following responsibilities require the use of professional judgement and therefore shall be performed only by a pharmacist or pharmacist intern:

(1) receipt of all new verbal prescription orders and reduction to writing;

(2) initial identification, evaluation and interpretation of the prescription order and any necessary clinical clarification prior to dispensing;

(3) professional consultation with a patient or his agent regarding a prescription;

(4) evaluation of available clinical data in patient medication record system;

(5) oral communication with the patient or patient's agent of information, as defined in this section under patient counseling, in order to improve therapy by ensuring proper use of drugs and devices;

(6) professional consultation with the prescriber, the prescriber's agent, or any other health care professional or authorized agent regarding a patient and any medical information pertaining to the prescription;

(7) drug regimen review, as defined in 61-11-2L;

(8) professional consultation, without dispensing, will require that the patient be provided with the identification of the pharmacist or pharmacy intern providing the service.

B. Only a pharmacist shall perform the following duties:

(1) final check on all aspects of the completed prescription including sterile products and cytotoxic preparations, and assumption of the responsibility for the filled prescription, including, but not limited to, appropriateness of dose, accuracy of drug, strength, labeling, verification of ingredients and proper container;

(2) evaluation of pharmaceuticals for formulary selection within the facility;

(3) supervision of all supportive personnel activities including preparation, mixing, assembling, packaging, labeling and storage of medications;

(4) ensure that supportive personnel have been properly trained for the duties they may perform;

(5) any verbal communication with a patient or patient's representative regarding a change in drug therapy or performing therapeutic interchanges (i.e. drugs with similar effects in specific therapeutic categories); this does not apply to substitution of generic equivalents;

(6) any other duty required of a pharmacist by any federal or state law.

C. Patient records.

(1) A reasonable effort must be made to obtain, record and maintain at least the following information:

(a) name, address, telephone number, date of birth (or age) and gender of the patient;

(b) individual medical history, if significant, including disease state or states, known allergies and drug reactions and a comprehensive list of medications and relevant devices; and

(c) pharmacists comments relevant to the individuals drug therapy.

(2) Such information contained in the patient record should be considered by the pharmacist or pharmacist intern in the exercise of their professional judgement concerning both the offer to counsel and the content of counseling.

D. Prospective drug review.

(1) Prior to dispensing any prescription, a pharmacist shall review the patient profile for the purpose of identifying:

(a) clinical abuse/misuse;

(b) therapeutic duplication;

(c) drug-disease contraindications;

(d) drug-drug interactions;

(e) incorrect drug dosage;

(f) incorrect duration of drug treatment;

(g) drug-allergy interactions;

(h) appropriate medication indication.

(2) Upon recognizing any of the above, a pharmacist, using professional judgment, shall take appropriate steps to avoid or resolve the potential problem. These steps may include requesting and reviewing a controlled substance prescription monitoring report or another states' reports if applicable and available, and consulting with the prescriber and counseling the patient. The pharmacist shall document steps taken to resolve the potential problem.

E. Prescription monitoring report for opiate prescriptions. When presented with an opiate prescription for a patient, obtaining and reviewing a prescription monitoring report for that patient can be an important tool that assists the pharmacist in identifying issues or problems that put his or her patient at risk of prescription drug abuse or diversion. A pharmacist shall use professional judgment based on prevailing standards of practice in determining whether to obtain and review a prescription monitoring report before dispensing an opiate prescription to that patient, and shall document his or her action regarding such reports.

(1) A pharmacist shall request and review a prescription monitoring report covering at least a one year time period and another states' report, where applicable and available if;

(a) a pharmacist becomes aware of a person currently exhibiting potential abuse or misuse of opiates (i.e. over-utilization, early refills, mulitple prescribers, appears overly sedated or intoxicated upon presenting a precription for an opiate or an unfamiliar patient requesting an opiate

by specific name, street name, color, or identifying marks, or paying cash when the patient has prescription insurance);

(b) a pharmacist receives an opiat prescription requesting the dispensing of opiates from a prescription issued by a prescriber with whom the pharmacist is unfamiliar (e.i. prescriber is located out-of-state or prescriber is outside the usual pharmacy geographic prescriber care area);

(c) providing opiates for a patient that is receiving chronic pain management prescriptions.

(2) After obtaining an initial prescription monitoring report on a patient, a pharmacist shall use professional judgment base on prevailing standards of practice, in deciding the frequency of requesting and reviewing further prescription monitoring reports and other states' reports for that patient. The pharmacist shall document the review of these reports.

(3) In the event a report is not immediately available, the pharmacist shall use professional judgment in determining whether it is appropriate and in the patient's best interest to dispense the prescription prior to receiving a report.

(4) A prescription for an opiate written for a patient in a long term care facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness is exempt from Subsection D of 16.19.29.8 NMAC. If there is any question whether a patient may be classified as having a terminal illness, the pharmacist shall contact the practitioner. The pharmacist shall document whether the patient is "terminally ill" or an "LTCF patient".

F. Counseling.

(1) Upon receipt of a new prescription drug order and following a review of the patient's record, a pharmacist or pharmacist intern shall personally offer to counsel on matters which will enhance or optimize drug therapy with each patient or the patient's agent. Upon receipt of a refill prescription drug order a pharmacy technician may query the patient or patient's agent regarding counseling by the pharmacist or pharmacist intern concerning drug therapy. Such counseling shall be in person, whenever practicable, or by telephone, and shall include appropriate elements of patient counseling which may include, in their professional judgement, one or more of the following:

(a) the name and description of the drug;

(b) the dosage form, dosage, route of administration, and duration of drug therapy;

(c) intended use of the drug and expected action;

(d) special directions and precautions for preparation, administration and use by the patient;

(e) common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance and the action required if they occur;

(f) techniques for self-monitoring drug therapy;

(g) proper storage;

(h) prescriptions refill information;

(i) action to be taken in the event of a missed dose;

(j) the need to check with the pharmacist or practitioner before taking other medication; and

(k) pharmacist comments relevant to the individual's drug therapy, including any other information peculiar to the specific patient or drug.

(2) [REPEALED]

(3) Alternative forms of patient information may be used to supplement patient counseling when appropriate. Examples include, but not limited to, written information leaflets, pictogram labels and video programs.

(4) Patient counseling, as described above and defined in this regulation shall not be required for in-patients of a hospital or institution where other licensed health care professionals are authorized to administer the drug(s).

(5) A pharmacist shall in no way attempt to circumvent or willfully discourage a patient or patient's agent from receiving counseling. However, a pharmacist shall not be required to counsel a patient or patients's agent when the patient or patients's agent refuses such consultation.

(6) When the patient or agent is not present when the prescription is dispensed, including but not limited to a prescription that was shipped by the mail, the pharmacist shall ensure that the patient receives written notice of available counseling. Such notice shall include days and hours of availability, and: (1) of his or her right to request counseling; and (2) a toll-free telephone number in which the patient or patient's agent may obtain oral counseling from a pharmacist who has ready access to the patient's record. For pharmacies delivering more than 50% of their prescriptions by mail or other common carrier, the hours of availability shall be a minimum of 60 hours per week and not less than 6 days per week. The facility must have sufficient toll-free phone lines and personnel to provide counseling within 15 minutes.

(7) In every pharmacy there shall be prominently posted in a place conspicuous to and readable by prescription drug consumers a notice concerning available counseling.

G. [REPEALED]

H. Regulatory assessment. Profiles, either electronic or hard copy, shall be available for inspection, and shall provide the capability of storing the described historical information. The profiles must demonstrate that an effort is being made to fulfill the requirements by the completion of the detail required. A patient record shall be maintained for a period of not less than three (3) years from the date of the last entry in the profile record.

[08-27-90; 16.19.4.16 NMAC - Rn, 16 NMAC 19.4.16, 03-30-02; 16.19.4.16 NMAC - Rn, 16.19.4.17 NMAC, 12-15-02; A, 02-01-04; A, 11-30-04; A, 01-15-05; A, 01-31-07; A, 08-31-12; A, 10-25-12]

16.19.4.17 PHARMACIST CLINICIAN:

A. Purpose: The purpose of these regulations is to implement the Pharmacist Prescriptive Authority Act, Sections 61-11B-1 through 61-11B-3 NMSA 1978 by providing minimum standards, terms and conditions for the certification, registration, practice, and supervision of pharmacist clinicians. These regulations are adopted pursuant to Section 61-11B-3 of the Pharmacist Prescriptive Authority Act.

B. Initial certification and registrants:

(1) The board may certify and register a pharmacist as a pharmacist clinician upon completion of an application for certification and satisfaction of the requirements set forth in these regulations.

(2) A pharmacist who applies for certification and registration as a pharmacist clinician shall complete application forms as required by the board and shall pay a fee. The fee shall be set by the board to defray the cost of processing the application, which fee is not returnable.

(3) To obtain initial certification and registration as a pharmacist clinician, she/he must submit the following:

(a) proof of completion of sixty (60) hour board approved physical assessment course, followed by a 150 hour, 300 patient contact preceptorship supervised by a physician or other practitioner with prescriptive authority, with hours counted only during direct patient interactions;

(b) the applicant will submit a log of patient encounters as part of the application;

(c) patient encounters must be initiated and completed within 2 years of the application.

(4) The board shall register each pharmacist certified as a pharmacist clinician.

(5) Upon certification and registration by the board, the name and address of the pharmacist clinician, (name of the supervising physician if applicable), and other pertinent information shall be enrolled by the board on a roster of pharmacist clinicians.

C. Biennial renewal of registration:

(1) Renewal applications shall be submitted prior to the license expiration.

(2) Applications for renewal must include:

(a) After January 1, 2013, documentation of continuing education hours, including proof of completion of 2.0 CEU twenty (20) contact hours of live CPE or continuing medical education (CME) approved by (ACPE) or AACME (live programs provided by other continuing education providers may be submitted for review and approval to the board), beyond the required hours in 16.19.4.10 NMAC (as amended), as required by the board; and

(b) a current protocol of collaborative practice signed by the supervising physician (if prescriptive authority is sought); and

(c) a copy of the pharmacist clinicians registration with the supervising physicians board (if prescriptive authority is sought); and

(d) other additional information as requested by the board.

D. Prescriptive authority, guidelines or protocol:

(1) Only a registered pharmacist clinician with current protocols, registered with the New Mexico medical board or the New Mexico board of osteopathic medical examiners, may exercise prescriptive authority.

(2) A pharmacist clinician seeking to exercise prescriptive authority shall submit an application to the board. The application must include the supervising physicians' name and current medical license, protocol of collaborative practice and other information requested by the board. A pharmacist may submit the application with the initial application for certification or as a separate application after becoming certified and registered as a pharmacist clinician.

(3) The protocol will be established and approved by the supervising physician as set forth in these regulations and will be kept on file at each practice site of the pharmacist clinician and with the board.

(4) The protocol must include:

(a) name of the physician(s) authorized to prescribe dangerous drugs and name of the pharmacist clinician;

(b) statement of the types of prescriptive authority decisions the pharmacist clinician is authorized to make, including, but not limited to:

(i) types of diseases, dangerous drugs or dangerous drug categories involved and the type of prescriptive authority authorized in each case;

(ii) ordering lab tests and other tests appropriate for monitoring of drug therapy;

[~~(ii)~~] **(iii)** procedures, decision criteria or plan the pharmacist clinician is to follow when exercising prescriptive authority;

(c) activities to be followed by the pharmacist clinician while exercising prescriptive authority, including documentation of feedback to the authorizing physician concerning specific decisions made; documentation may be made on the prescriptive record, patient profile, patient medical chart or in a separate log book;

(d) description of appropriate mechanisms for consulting with the supervising physician, including a quality assurance program for review of medical services provided by the pharmacist clinician, (this quality assurance program will be available for board review); and

(e) description of the scope of practice of the pharmacist clinician.

E. Scope of practice:

(1) A pharmacist clinician shall perform only those services that are delineated in the protocol and are within the scope of practice of the supervising physician and/or alternate supervising physician(s).

(2) A pharmacist clinician may practice in a health care institution within the policies of that institution.

(3) A pharmacist clinician may prescribe controlled substances provided that the pharmacist clinician:[~~(i)~~]

(a) has obtained a New Mexico controlled substances registration and a drug enforcement agency registration, and [~~(ii)~~]

(b) prescribes controlled substances within the parameters of written guidelines or protocols established under these regulations and Section 3, A. of the Pharmacist Prescriptive Authority Act.

(4) The board may, in its discretion after investigation and evaluation, place limitations on the tasks a pharmacist clinician may perform under the authority and direction of a supervising physician and/or alternate supervising physician(s).

F. Collaborative professional relationship between pharmacist clinicians and supervising physician(s):

(1) The direction and supervision of pharmacist clinicians may be rendered by approved supervising physician/designated alternate supervising physician(s).

(2) This direction may be done by written protocol or by oral consultation. It is the responsibility of the supervising physician to assure that the appropriate directions are given and understood.

(3) The pharmacist clinician must have prompt access to consultation with the physician for advice and direction.

(4) Upon any change in supervising physician between registration renewals, a pharmacist clinician shall submit to the board, within ten (10) working days, the new supervising physician's name, current medical license, and protocol; notification to and completion of requirements for the supervising physicians' board shall be completed per that boards requirements. This notice requirement does not apply to an alternate supervising physician who is designated to cover during the absence of the supervising physician.

G. Complaints and appeals:

(1) The chair of the board will appoint two (2) members of the board, and the president of the supervising physician respective board will appoint (2) members of the respective board to the oversight committee; the oversight committee will review complaints concerning the pharmacist clinician practice; the oversight committee will make a report that may include non-binding recommendations to both the board and respective board(s) regarding disciplinary action. Each board can accept or reject the recommendations.

(2) Any applicant for certification or any pharmacist clinician may appeal a decision of the board in accordance with the provisions of the Uniform Licensing Act, Sections 61-1-1 to 61-1-33 NMSA 1978.

[03-14-98; 16.19.4.17 NMAC - Rn, 16 NMAC 19.4.17, 03-30-02; 16.19.4.17 NMAC - Rn, 16.19.4.18 NMAC, 12-15-02; A, 09-30-03; A, 01-31-07; A, 05-14-10; A, 08-16-10; A, 10-25-12]

NEW MEXICO BOARD OF PHARMACY

This is an amendment to 16.19.15 NMAC, Sections 1, 3, 6, 7, and 9, effective 10-25-12.

16.19.15.1 ISSUING AGENCY: Regulation and Licensing Department, Board of Pharmacy,[~~1650 University Blvd, NE - Ste. 400B,~~] Albuquerque NM [~~87102. (505) 841-9102~~].

[02-15-96; 16.19.15.1 NMAC - Rn, 16 NMAC 19.15.1, 03-30-02; A, 10-25-12]

16.19.15.3 STATUTORY AUTHORITY: Section 61-11-14.B. (13) NMSA 1978 authorizes the board of pharmacy to issue drug permits for wholesalers, retailers and distributors of dangerous drugs limited to veterinary use. **Section 26-3-3(A) NMSA 1978 (the Drug Product Selection Act or "DPSA") authorizes pharmacists to dispense lower cost versions of multiple-source drugs that meet a final determination of the federal government that is published in the federal register. Section 26-3-2 of the DPSA states that the purpose of the DPSA is to assure that all New Mexico citizens continue to receive high quality drugs at a reasonable cost.**

[02-15-96; A, 04-30-98; 16.19.15.3 NMAC - Rn, 16 NMAC 19.15.3, 03-30-02; A, 10-25-12]

16.19.15.6 OBJECTIVE: The objective of Part 15 of Chapter 19 is to establish standards to be followed by retailers and distributors for the safe and competent delivery, distribution, and disposal of dangerous drugs limited to veterinary use **and to carry out the purpose of the Drug Product Selection Act by providing a uniform standard for drug product selection of animal drugs. Section 26-3-3(A) NMSA 1978 permits a pharmacist to select a lower cost multiple source drug that meets a final determination in the federal register when a more costly version of the drug is prescribed. Animal drugs approved by FDA are subject to final determinations in the federal register and therefore qualify for drug product selection as described in this regulation**.
[02-15-96; 16.19.15.6 NMAC - Rn, 16 NMAC 19.15.6, 03-30-02; A, 10-25-12]

16.19.15.7 DEFINITIONS:

A. **"Limited licensure for retailers of veterinary drugs"** means a license issued in accordance with the Pharmacy Act 61-11-14.B (13), which authorizes licensees to retail dangerous drugs limited to veterinary use, in accordance with the labeling provisions of the Drug and Cosmetic Act.

B. **"Dangerous drug"** means a drug...because of any potentiality for harmful effect or the method of its' use, or the collateral measures necessary to its' use, is not safe except under the supervision of a practitioner licensed by law to direct the use of such drug, and hence for which adequate directions for use cannot be prepared.

C. "Animal drug" means a dangerous (prescription) drug that is the subject of an approved new animal drug application or an approved abbreviated new animal drug application under the Federal Food, Drug, and Cosmetic Act.

D. "FDA" means the United States food and drug administration.

[~~C.~~] **E. "Adequate directions for use"** means directions under which the layman can use a drug safely and for the purpose for which it is intended. A dangerous drug shall be sold at retail only on the order or prescription of a practitioner licensed by law to administer or prescribe such drug, if it bears the legend: "CAUTION -- federal law restricts this drug to use by or on the owner of a licensed veterinarian".

[~~D.~~] **F. "Licensed practitioner"** means a person engaged in a profession licensed by the state, who within the limits of his license, may lawfully prescribe, dispense or administer drugs for the treatment of a patient's condition, and includes doctors of medicine, osteopathy, dentistry, podiatry and veterinary medicine.

[~~E.~~] **G. "Prescription"** means an order given individually for the person for whom prescribed, either directly from the prescriber or indirectly by means of a written order, signed by the prescriber and shall bear the name and address of the prescriber, his license classification, the name and address of the patient, the name and quantity of the drug prescribed, directions for use and the date of issue. No person other than a licensed practitioner shall prescribe or write a prescription.

H. "Therapeutically equivalent" means animal drug products which have the same amount of the active drug in the same dosage form which when administered can be expected to provide the same therapeutic effect.

[~~F.~~] **I. "Expiration date"** means those drugs and particularly those that are biologic in origin, on which the label is required to bear an expiration date limiting the period during which the drug may be expected to have the labeled potency if it is stored as directed.

[~~G.~~] **J. "Proper storage temperature"** means the temperature at which the label on the drug indicates the product must be kept.

(1) Cold; any temperature not exceeding 46 degrees F.

(2) Cool; any temperature between 46 and 50 degrees F.

(3) Room temperature; the temperature prevailing in a working area.

(4) Controlled room temperature; temperature maintained thermostatically between 59 and 86 degrees F.

(5) Excessive heat; any temperature above 104 degrees F.

(6) Protection from freezing; where, in addition to the risk of breakage of the original container, freezing subjects a product to a loss of strength or potency, or to destructive alteration of the dosage form. The container label bears the appropriate notice to protect from freezing.
[03-07-80...08-27-90, 04-30-98; 16.19.15.7 NMAC - Rn, 16 NMAC 19.15.7, 03-30-02; A, 10-25-12]

16.19.15.9 DANGEROUS VETERINARY DRUGS AND ANIMAL DRUG PRODUCT SELECTION: All dangerous drugs distributed at retail on the order of a licensed veterinarian by the limited retail veterinary drug distributor shall be sold in the original, unbroken manufacturer's containers.

A. Upon receipt of a prescription for an animal drug, a pharmacist may dispense any lower cost animal drug that is:

(1) therapeutically equivalent to the prescribed animal drug;

(2) bioequivalent to the prescribed animal drug; and

(3) listed in FDA's list of approved animal drug products (the "green book").

B. When performing animal drug product selection pursuant to this regulation, a pharmacist may rely on the bioequivalence information found in the FDA FOIA summaries published on the FDA internet website.

C. A licensed practitioner may prohibit animal drug product selection by writing with his hand the words "no substitution" or the diminution "no sub" on the face of a prescription.

D. If animal drug product selection occurs as permitted in this regulation, the pharmacist shall indicate on the label of the dispensed container the brand of drug prescribed and the name of the drug dispensed.

E. A pharmacist may not select a therapeutically equivalent animal drug unless he passes on to the purchaser all savings between the net cost of the product prescribed and the product dispensed.
[03-07-80...08-27-90; 16.19.15.9 NMAC - Rn, 16 NMAC 19.15.9, 03-30-02; A, 10-25-12]

NEW MEXICO PUBLIC REGULATION COMMISSION
INSURANCE DIVISION

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 26 REGISTRATION OF PRIVATE HEALTH INSURANCE COOPERATIVES

13.10.26.1 ISSUING AGENCY: New Mexico Public Regulation Commission, Insurance Division.
[13.10.26.1 NMAC - N, 10-15-12]

13.10.26.2 SCOPE: This rule applies to private health insurance cooperatives established under Chapter 59A, Article 23 NMSA 1978.
[13.10.26.2 NMAC - N, 10-15-12]

13.10.26.3 STATUTORY AUTHORITY: Sections 59A-2-9 and 59A-23-3 NMSA 1978.
[13.10.26.3 NMAC - N, 10-15-12]

13.10.26.4 DURATION: Permanent.
[13.10.26.4 NMAC - N, 10-15-12]

13.10.26.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.
[13.10.26.5 NMAC - N, 10-15-12]

13.10.26.6 OBJECTIVE: To establish minimum registration requirements for private health insurance cooperatives.
[13.10.26.6 NMAC - N, 10-15-12]

13.10.26.7 DEFINITIONS:

A. "Private health insurance cooperative" means a nonprofit corporation formed to arrange for health benefit plan coverage with insurance carriers for its participating member large or small employers.

B. "Carrier" means carrier as defined in Section 59A-23-11.Q (1) NMSA 1978.

C. "Large employer" means a large employer as defined in Section 59A-23-11.Q (2) NMSA 1978.

D. "Small employer" means a small employer as defined in as defined in Section 59A-23-11.Q (3) NMSA 1978.
[13.10.26.7 NMAC - N, 10-15-12]

13.10.26.8 REGISTRATION REQUIREMENTS:

A. Any private health insurance cooperative operating in New Mexico shall register with the agent licensing bureau of the insurance division of the New Mexico public regulation commission prior to commencing operations.

B. All business entities should be aware that other licensing and registration requirements for corporations and partnerships may exist. Corporations may contact the corporations bureau of the New Mexico public regulation commission at (505) 827-4387 to determine the applicable requirements and to register. Partnerships may contact the secretary of state's office (505) 827-3600 to determine the applicable requirements and to register.

C. The registration process with the agent licensing bureau of the insurance division shall include verification that the private health insurance cooperative:

(1) has provided:

(a) name;

(b) New Mexico public regulation commission corporations number;

(c) New Mexico address as registered;

(d) New Mexico city of registration;

(e) state and zip code of registration;

(f) sufficient evidence that the entity is in good standing with the secretary of state (if the date is not identical to the current date, then the agent licensing bureau shall notify the private health insurance cooperative that it may not negotiate contracts until its good standing is re-established);

(g) member-employer names, addresses, cities of registration, states, zip codes, and New Mexico tax I.D. numbers; and

(h) the private health insurance cooperative's employee names and addresses;

(2) has not been formed by, nor has as a member, a carrier, pursuant to the prohibition in Chapter 59A, Article 23 NMSA 1978;

(3) has established procedures under which an applicant for or participant in its group health benefit plan coverage may have a grievance reviewed by an impartial entity, specifically by requiring the carrier to electronically file a non-grandfathered grievance plan with the New Mexico public regulation commission, insurance division, managed health care bureau that shall be subject to and comply with the insurance division's grievance procedures rule pertaining to internal and external grievance review (13.10.17 NMAC);

(4) has developed and implemented a plan to maintain public awareness of the private health insurance cooperative and publicize the eligibility requirements for, and the procedures for enrollment in, its group health benefit plan coverage;

(5) in instances wherein the private health insurance cooperative has made available to its members more than one group health benefit plan, has made each group health benefit available to all employees covered by the cooperative;

(6) ensures that any group health benefit plan provided through the private health insurance cooperative provides coverage for diabetes equipment, supplies and services;

(7) does not self-insure or self-fund any health benefit plan or portion of a plan; and

(8) has contracted only with a carrier that demonstrates that it:

(a) is in good standing with the division;

(b) has the capacity to administer health benefit plans;

(c) is able to monitor and evaluate the quality and cost-effectiveness of care and applicable procedures;

(d) is able to conduct utilization management and establish applicable procedures and policies;

(e) is able to ensure that enrollees have adequate access to health care providers, including adequate numbers and types of providers;

(f) has a satisfactory grievance procedure that is subject to and shall comply with the insurance division's grievance procedures rule (13.10.17 NMAC) and is able to respond to enrollees' calls, questions and complaints; and

(g) has financial capacity, either through satisfying solvency standards that the superintendent shall set or through appropriate reinsurance or other risk-sharing mechanisms.
[13.10.26.8 NMAC - N, 10-15-12]

13.10.26.9 ANNUAL REQUIRED FILING:

A. Each private health insurance cooperative shall file an annual report for the preceding calendar year with the superintendent on or before March 1 of each year, or within such extension of time as the superintendent for good cause may grant. The report shall be in the form and contain such matters as the superintendent prescribes and shall be verified by at least two officers or two partners of the private health insurance cooperative.

B. The annual report shall include the complete names and addresses of all insurers with which the private health insurance cooperative had an agreement during the preceding fiscal year. If requested in writing by the private health insurance cooperative, the names and addresses of the insureds may be kept confidential by the superintendent.
[13.10.26.9 NMAC - N, 10-15-12]

HISTORY OF 13.10.26 NMAC: [RESERVED]

End of Adopted Rules Section

Other Material Related to Administrative Law

NEW MEXICO BOARD OF EXAMINERS FOR ARCHITECTS

New Mexico Board of Examiners for Architects

PO Box 509
Santa Fe, NM
505-982-2869

Regular Meeting

The New Mexico Board of Examiners for Architects will hold a regular open meeting of the Board in Santa Fe, New Mexico on Friday, November 9, 2012. The meeting will be held in the Conference Room of the Board office, #5 Calle Medico, Ste. C in Santa Fe beginning at 9:00 a.m. Disciplinary matters may also be discussed.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or other form of auxiliary aid or service to attend or participate in the meeting, please contact the Board Office at 982-2869 at least one week prior to the meeting. Public documents, including the agenda and minutes can be provided in various accessible formats. Please contact the Board Office if a summary or other type of accessible format is needed.

End of Other Related Material Section

Submittal Deadlines and Publication Dates

2012

Volume XXIII	Submittal Deadline	Publication Date
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

2013

Volume XXIV	Submittal Deadline	Publication Date
Issue Number 1	January 2	January 15
Issue Number 2	January 16	January 31
Issue Number 3	February 1	February 14
Issue Number 4	February 15	February 28
Issue Number 5	March 1	March 15
Issue Number 6	March 18	March 29
Issue Number 7	April 1	April 15
Issue Number 8	April 16	April 30
Issue Number 9	May 1	May 15
Issue Number 10	May 16	May 31
Issue Number 11	June 3	June 14
Issue Number 12	June 17	June 28
Issue Number 13	July 1	July 15
Issue Number 14	July 16	July 31
Issue Number 15	August 1	August 15
Issue Number 16	August 16	August 30
Issue Number 17	September 3	September 16
Issue Number 18	September 17	September 30
Issue Number 19	October 1	October 15
Issue Number 20	October 16	October 31
Issue Number 21	November 1	November 14
Issue Number 22	November 15	November 27
Issue Number 23	December 2	December 13
Issue Number 24	December 16	December 30

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.