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Volume XXVII - Issue 4 - February 29, 2016

New Mexico Register

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Notices of Rulemaking and Proposed Rules

HEALTH, DEPARTMENT OF

Notice of Public Hearing

The New Mexico Department of Health will hold a public hearing on 7.4.3 New Mexico Administrative Code (NMAC) "Control of Disease and Conditions of Public Health Significance" at 9:00 am on Friday, March 18, 2016 in the Harold Runnels building Auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico 87502.

The public hearing will be conducted to add certain diseases or conditions as notifiable diseases or conditions, clarify reporting fax or phone numbers, and make certain clarifications and modifications to the existing regulation.

A copy of the proposed regulation can be obtained from:
Monica Roybal
New Mexico Department of Health
1190 St. Francis Drive
PO Box 26110
Santa Fe, NM 87502-6110
505-476-3035

Please submit any written comments regarding the proposed regulation to the attention of Monica Roybal at the above address prior to the hearing. You may also submit oral comments during the public hearing itself.

If you are an individual with a disability who is in need of special assistance or accommodation to attend or participate in the hearing, please contact Monica Roybal by telephone at 505-476-3035. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

MINING COMMISSION

The New Mexico Mining Commission will hold a regular meeting and a public hearing at 9:00 AM, Wednesday, April 20, 2016 (and Thursday, April 21, 2016, if necessary), in Porter Hall on the 1st floor of the Wendell Chino Building, 1220 South Saint Francis Drive in Santa Fe, New Mexico.

During the meeting, the Mining Commission will conduct a public hearing on a petition for rulemaking submitted by the New Mexico Mining Association (15-02) to amend 19.10.3 NMAC (Minimal Impact Rule) "…to expand the disturbance area for minimal impact mining operations for non-energy fuel minerals that lack the potential for significant acid drainage from ten acres to forty acres in all areas of New Mexico except Bernalillo County, Dona Ana County, and Santa Fe County." At the conclusion of the hearing, the Mining Commission may deliberate and take action on the petition. In addition, the Commission may consider other matters that come before it, including adoption of the Commission's 2016 Open Meetings Act Resolution.

The Commission's Guidelines for Rulemaking can be found at http://www.emnrd.state.nm.us/MMD/NMMC/documents/guidelinesforrulemaking.pdf. Any person intending to present technical testimony at the public hearing must submit a notice of intent that identifies the party and the name of the technical witness, summarizes the testimony, includes any recommended modifications to the regulatory proposal, and lists and describes all anticipated exhibits. Notices of Intent to Present Technical Testimony must be received by Jane Tabor, Clerk of the Mining Commission, C/O Mining and Minerals Division, 1220 South St. Francis Drive, Santa Fe, New Mexico 87505 not later than 5:00 PM, Wednesday, April 6, 2016, and should reference the petition number and the date of the hearing. Any member of the public may testify at the hearing. No prior notification to the Clerk is required to present non-technical testimony at the hearing. Any person may submit a written statement at the hearing, or may file the written statement prior to the hearing to the address listed in this notice.

A copy of the petition with the proposed regulatory change can be obtained on the MMD website at http://www.emnrd.state.nm.us/MMD/NMMC/MineCommProposedRuleChanges.html or by contacting Jane Tabor at 476-3400. A copy of the draft agenda for the meeting/hearing will be available on the website 72 hours before the meeting or may be obtained by contacting Jane Tabor at 476-3400. If you need a reader, amplifier, qualified sign language interpreter or any other form of auxiliary aid or service to attend or participate in the hearing, please contact Jane Tabor at 476-3400 at least 48 hours prior to the hearing.

REGULATION AND LICENSING DEPARTMENT

NURSING HOME ADMINISTRATORS BOARD

Public Rule Hearing and Regular Board Meeting

The New Mexico Nursing Home Administrators Board will hold a rule hearing on Wednesday, March 30, 2016. Following the rule hearing, the New Mexico Nursing Home Administrators Board will convene a regular meeting to adopt the rules and take care of regular business. The New Mexico Nursing Home Administrators Board rule hearing will begin at 10:00 a.m. and the regular meeting will convene following the rule hearing. The meetings will be held in the main conference room, at the Regulation and Licensing Department, located at 5500 San Antonio Drive NE, Albuquerque, New Mexico.

The purpose of the rule hearing is to consider adopting a new part to the board rules in 16.13. NMAC: The new part is 16.13.6 NMAC: Licensure for Military Service Members, Spouses and Veterans, and amendments and additions to 16.13.1 NMAC: General Provisions, 16.13.3 NMAC: Application for Licensure by Examination, 16.13.8 NMAC: License Renewal, 16.13.10 NMAC: Expired License and 16.13.12 NMAC: License Reactivation.

The board may go into executive session pursuant to 10-15-1.H of the Open Meetings Act to discuss pending complaints and licensure issues. A final agenda for the board meeting will be available at the board office at least 72 hours prior to the meeting and can be obtained on the website at www.rld.state.nm.us.

Persons desiring to present their views on the proposed rules may write to request draft copies from the board office at the Toney Anaya Building located at 2550 Cerrillos Road in Santa Fe, New Mexico, or call (505) 476-4622 after February 29, 2016 or from the board's website http://www.rld.state.nm.us/boards/.

In order for the board members to review the comments in their meeting packets prior to the meeting, persons wishing to make comments regarding the proposed rules must present them to the board office in writing no later than March 15, 2016. Persons wishing to present their comments at the hearing will need (10) copies of any comments or proposed changes for distribution to the board and staff.

If you have questions, or if you are an individual with a disability who wishes to attend the hearing or meeting, but you need a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to participate, please call the board office at (505) 476-4622 at least two weeks prior to the meeting or as soon as possible.

Gabriella Romero, Administrator
PO Box 25101, Santa Fe, NM 87505

REGULATION AND LICENSING DEPARTMENT
PRIVATE INVESTIGATIONS ADVISORY BOARD

Public Rule Hearing and Regular Board Meeting

The New Mexico Private Investigations Advisory Board will hold a Rule Hearing on Tuesday, April 5, 2016. Following the Rule Hearing the New Mexico Private Investigations Advisory Board will convene a regular meeting to adopt the rules and take care of regular business. The New Mexico Private Investigations Advisory Board Rule Hearing will begin at 9:00 a.m. and the Regular Board Meetings will convene following the rule hearing. The meetings will be held at the Regulation and Licensing Department, Toney Anaya Building, 2500 Cerrillos Road, Santa Fe, NM, 87505, in the Rio Grande Conference Room.

The purpose of the rule hearing is to consider adoption of proposed amendments to the following Board Rules and Regulations in 16.48.5 NMAC, Fees.

You can contact the board office at the Toney Anaya Building located at 2550 Cerrillos Road in Santa Fe, New Mexico 87505, call (505) 476-4622 for copies of the proposed rules. The proposed rules are also available on the Private Investigations Advisory Board's website: www.RLD.state.nm.us. In order for the Board members to review the comments in their meeting packets prior to the meeting, persons wishing to make comment regarding the proposed rules must present them to the Board office in writing no later than March 17, 2016. Persons wishing to present their comments at the hearing will need fifteen (15) copies of any comments or proposed changes for distribution to the Board and staff.

A copy of the agenda will be available at least 72 hours prior to the meeting and may be obtained at the Board office located on the 2nd Floor of the Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, NM, or by calling the Board office at (505) 476-4630 and will also be posted on our website at www.rld.state.nm.us Private Investigations Advisory Board, under Members and Meetings.

If you have questions, or if you are an individual with a disability who wishes to attend the hearing or meeting, but you need a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to participate, please call the Board office at (505) 476-4622 at least two weeks prior to the meeting or as soon as possible.

End of 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 in the State Rules Act. Unless a later date is otherwise provided by law, the effective date of the rule shall be the date of publication in the New Mexico Register. Section 14-4-5 NMSA 1978.

FINANCE AND ADMINISTRATION, DEPARTMENT OF

TITLE 2 PUBLIC FINANCE
CHAPTER 61 STATE INDEBTEDNESS AND SECURITIES
PART 8 APPROVAL OF REFUNDING BONDS

2.61.8.1 ISSUING AGENCY: Department of Finance and Administration, 180 Bataan Memorial Building, Santa Fe, NM 87501.
[2.61.8.1 NMAC - N, 2/29/2016]

2.61.8.2 SCOPE: Any issuance of refunding bonds that, pursuant to Section 3-31-9 NMSA 1978, Section 4-62-8 NMSA 1978, or Section 6-15-11 NMSA 1978, requires department of finance and administration approval.
[2.61.8.2 NMAC - N, 2/29/2016]

2.61.8.3 STATUTORY AUTHORITY:

A. Section 3-31-9 NMSA 1978 provides that a municipality shall receive from the department of finance and administration written approval of any gross receipts tax refunding revenue bonds, gasoline tax refunding revenue bonds or project refunding revenue bonds pursuant to the provisions of Sections 3-31-8 through 3-31-12 NMSA 1978.

B. Section 4-62-8 NMSA 1978 provides that a county shall receive from the department of finance and administration written approval of any non-utility gross receipts tax refunding bonds, gasoline tax refunding revenue bonds, fire protection refunding revenue bonds, environmental refunding revenue bonds, or non-utility project refunding revenue bonds issued pursuant to the provisions of Sections 4-62-7 through 4-62-10 NMSA 1978.

C. Section 6-15-11 NMSA 1978 provides that the governing body of any county, municipality or school district in this state may, with the approval of the department of finance and administration, issue bonds in such form as the governing body may determine, to be denominated refunding bonds, for the purpose of refunding any of the general obligation bonded indebtedness of the county, municipality or school district which has or will become due and payable or which has or will become payable at the option of the county, municipality or school district by consent of the bondholders or by any lawful means.

D. Section 6-15-12 NMSA 1978 provides that whenever a governing body of a county, municipality or school district deems it expedient to issue refunding bonds under the provisions of Sections 6-15-11 to 6-15-22 NMSA 1978, the governing body shall adopt an ordinance or resolution setting out the facts making the issuance of such refunding bonds necessary or advisable, the determination of such necessity or advisability of said governing body, and the amount of such refunding bonds which it is deemed necessary and advisable to issue.
[2.61.8.3 NMAC - N, 2/29/2016]

2.61.8.4 DURATION: Permanent.
[2.61.8.4 NMAC - N, 2/29/2016]

2.61.8.5 EFFECTIVE DATE: February 29, 2016, unless a later date is cited at the end of a section.
[2.61.8.5 NMAC - N, 2/29/2016]

2.61.8.6 OBJECTIVE: This rule provides general guidance regarding the financial and legal requirements for department approval of certain refunding bond issues as required by state statute. The rule is intended to benefit the state's political subdivisions in their refunding bond policies. Department approval of proposed refunding bonds is not intended to protect investors and does not evidence the soundness of any investment. Department approval is based solely on information provided by the issuing authority. The department has no duty to independently investigate, and does not independently investigate, the merits and risks involved in the refunding bonds.
[2.61.8.6 NMAC - N, 2/29/2016]

2.61.8.7 DEFINITIONS:

A. "All-inclusive interest cost" means the total cost of the refunding bonds, expressed as a discount rate calculated using the present value of all debt service payments on the refunding bonds and the total proceeds of the refunding bonds. The amount of refunding proceeds is adjusted by any accrued interest, original issue discount, original discount premium, costs of issuance, credit enhancement fees, and underwriter's spread.

B. "Costs of issuance" means all costs incurred by the issuing authority incident to the planning and sale of the refunding bonds. Costs of issuance include but are not limited to underwriters' spread, discount, or fees, counsel fees, financial advisor fees, credit enhancement costs, rating agency fees, trustee fees, accountant fees, printing costs, loan origination fees, administrative costs and costs incurred in connection with the required public notice process.

C. "Department" means the department of finance and administration.

D. "Financing documents" means any official statement, bond purchase agreement, indenture, liquidity facility, credit enhancement agreement, loan agreement or other similar agreement associated with the issuance of the refunding bonds.

E. "Issuing authority" for purposes of refunding bonds that by law require department approval, means the governmental unit or public body in the name of which refunding bonds are issued. For these purposes, issuing authorities include, but are not limited to, counties, school districts and municipalities.

F. "Refunded bonds" means a written promise to pay a specified sum of money (par value or principal amount) at a specified date or dates in the future (maturity dates) together, if applicable, with interest, that is proposed to be refunded through the issuance of refunding bonds. Refunded bonds include, for these purposes, but without limitation:

(1) tax revenue bonds, gasoline tax revenue bonds,

or project revenue bonds issued by a municipality pursuant to Sections 3-31-1 through 3-31-7 NMSA 1978;

(2) non-utility gross receipts tax bonds, gasoline tax revenue bonds, fire protection revenue bonds, environmental revenue bonds, or non-utility project revenue bonds issued pursuant to the provisions of Sections 4-62-1 through 4-62-6 NMSA 1978; or

(3) general obligation bonds issued by a county, municipality or school district pursuant to Sections 6-15-3 through 6-15-10 NMSA 1978.

G. "Refunding bonds" means bonds issued to refinance refunded bonds. These include current and advance refunding within the meaning of the Internal Revenue Code of 1986, as amended.

H. "True-interest-cost" means that yield, which if used to compute the present worth as of the delivery date of the refunding bonds of all payments of principal and interest to be made on the refunding bonds from their delivery date to their respective maturity dates (as specified in the maturity schedule and without regard to the possible optional prior redemption of the refunding bonds), using the interest rate specified in the bid or purchase contract produces an amount equal to the principal amount of the refunding bonds, plus any premium or minus any discount bid or stated in the purchase contract. Such calculation shall be based on a 360 day year consisting of 12, 30-day months and a semi-annual compounding interval. [2.61.8.7 NMAC - N, 2/29/2016]

2.61.8.8 FINANCING PLAN FOR REFUNDING BONDS:

A. In order to obtain approval of the issuance of refunding bonds, the issuing authority must prepare a financing plan prior to the sale of the refunding bonds that addresses the following:

(1) Refunding details:

(a)
Estimated gross and net present value savings annually, if any, by each series of refunded bonds. If the refunding bonds are being issued together with new money bonds, the net present value savings calculation on the refunding bonds should exclude any interest payments or proceeds associated with the new money bonds.

(b)
Interest rate and debt service comparisons between refunding bonds and their respective refunded bonds.

(c)
Description of sources and uses of funds.

(d)
If request is for approval of advance refunding bonds, redemption dates and call premiums on refunded bonds with an analysis of the potential costs and benefits of delay of issuing the refunding bonds, description of any special arbitrage issues, and type of proposed investments to be used for escrow accounts.

(2) Debt management:

(a)
Current outstanding debt and relation of the proposed refunding bonds to financial, parity bond and rate limits, if any.

(b)
Five-year history of pledged revenues used for proposed debt service based on fiscal year audited financial statements.

(c)
Current and five-year projected coverage ratios, based on current revenues, on annual debt service requirements by:

(i)
Pledged revenue.

(ii)
Total revenue legally available for debt service.

(iii)
Maximum fiscal year debt service as a percentage of prior fiscal year audited pledged revenue, if available.

(d)
For general obligation refunding bonds, current ad valorem mill levy imposed, maximum mill levy allowable by law, and the anticipated impact the refunding bonds will have on the mill levy.

(3) Debt structure and terms:

(a)
Maturity structure of proposed refunding bonds.

(b)
Estimated interest rates on proposed refunding bonds including true-interest-cost, all-inclusive interest cost, and average coupon.

(c)
Estimated life of the refunding bonds.

(d)
Table showing, on a fiscal year basis, total future debt payments by:

(i)
New refunding issue.

(ii)
Outstanding issues less refunded bonds.

(iii)
Total debt payments (new refunding issue and outstanding issues less refunded bonds).

(e)
Estimated terms and conditions of refunding bonds including covenant and call provisions, if applicable.

(f)
Maximum principal amount and the maximum interest rate allowed for refunding bond sale.

(4) Sales management:

(a)
Representation and compensation of financial advisor, if any, and method of selection.

(b)
Method of sale, including justification for a negotiated sale, if any, and, if negotiated, method of selection of underwriter.

(c)
Representation and compensation of bond counsel, special tax counsel, if any, and disclosure counsel, if any, and indication of method of selection.

(d)
Breakout of costs of issuance. For negotiated sales, cost of issuance breakout should include underwriters' discount as broken out by management fee, structuring fee, take down and estimated expenses.

(e)
Anticipated timing of sale.

(5) Legal documents:

(a)
All resolutions and ordinances previously adopted by the issuing authority relating to the refunding bonds.

(b)
Drafts of all resolutions and ordinances to be adopted by the issuing authority relating to the refunding bonds.

(c)
Copies (or drafts if not in final form) of all financing documents.

(6) Additional information:

(a)
A certification of the issuing authority certifying that the issuing authority has complied with all statutory requirements for the issuance of refunding bonds.

(b)
Any other information that the department, in its discretion, needs and requests in order to fulfill its duty to review and approve the refunding bonds.

B. The department shall make its determination to approve or disapprove of refunding bonds based on its assessment of the financing plan, including, in part, whether the refunding bonds will achieve net present value savings of at least three percent of the

par amount of refunded bonds. The department may approve refunding bonds that generate less than three percent savings or disapprove refunding bonds that generate more than three percent savings in its sole discretion, depending upon other factors related to the refunding bonds.

C. The department, in its sole discretion, may waive specific provisions of this rule when circumstances warrant.

[2.61.8.8 NMAC - N, 2/29/2016]

2.61.8.9 FINAL STATUTORY APPROVAL BY THE DEPARTMENT ON ISSUANCE OF REFUNDING BONDS:

A. If the refunding bonds have not yet been sold at the time department approval is contemplated, the department may approve the issuance of refunding bonds by sending correspondence establishing parameters including the maximum principal amount, the maximum true interest cost, maximum coupon on each maturity, the maximum final maturity date, and final closing date for the refunding bonds. The issuing authority must include proposed parameters in its request to the department for approval and the department may request changes to the proposed parameters as a condition of its approval. Following the sale but at or before closing, the issuing authority will certify in writing to the department that the results of the sale are in compliance with all parameters, terms and conditions set by the department and include in the certification a report of the results of the sale with respect to each parameter. An issuing authority's failure to provide a full and accurate certification to the department on or before the final closing date will result in the department not having provided its approval to the issuing authority.

B. If the refunding bonds have been sold but not yet issued or closed at the time department approval is contemplated, the department may approve the issuance of the refunding bonds by sending correspondence communicating its final approval.

C. The issuing authority shall not deliver the refunding bonds to the purchasers until after the issuing authority has received written confirmation from the department that it has given its final approval.

D. The refunding bonds must be delivered to the purchasers by the issuing authority no later than any date established in the department correspondence. If the refunding bonds are not delivered to the purchasers by the issuing authority by any date set in the department correspondence, the issuing authority must prepare and present a new financing plan to the department.

E. If the department denies approval of the refunding bonds, the department will send written communication to the issuing authority stating that the request for approval of refunding bonds has been denied and summarizing the basis for its denial.

[2.61.8.9 NMAC - N, 2/29/2016]

2.61.8.10 SUBMISSION OF FINANCING PLAN TO THE DEPARTMENT:

A. A financing plan submitted to the department must address each of the specific items in this rule, if applicable.

B. One original hard copy and one identical electronic version of the financing plan must be submitted to the department. Municipalities and counties must also submit copies to the local government division of the department, and school districts must also submit copies to the public education department. The hard copy must be tabbed for easy reference and the electronic version should be bookmarked.

C. A financing plan, in its entirety, must be submitted at least 15 business days before the date on which established parameters or final approval is requested to be communicated by the department.

[2.61.8.10 NMAC - N, 2/29/2016]

HISTORY OF 2.61.8 NMAC:
[**RESERVED**]

HEALTH, DEPARTMENT OF

TITLE 7 HEALTH
CHAPTER 10 FREESTANDING BIRTH CENTERS
PART 2 REQUIREMENTS FOR FREESTANDING BIRTH CENTERS

7.10.2.1 ISSUING AGENCY: New Mexico Department of Health, Division of Health Improvement.

[7.10.2.1 NMAC - N, 3/1/2016]

7.10.2.2 SCOPE:

A. These regulations apply to public, for profit and non-profit freestanding birth centers providing the services specified in these regulations. Any freestanding birth center providing services specified in these regulations must be licensed under these regulations prior to obtaining federal certification.

B. These regulations do not apply to:

(1) hospitals that provide labor and delivery services under their hospital license;

(2) births performed in a private residence by licensed midwives or certified nurse midwives acting within the scope of their license; and

(3) offices and treatment rooms of a licensed private practitioners.

[7.10.2.2 NMAC - N, 3/1/2016]

7.10.2.3 STATUTORY AUTHORITY: The regulations set forth herein are promulgated by the secretary of the New Mexico department of health, pursuant to the general authority granted under Subsection E of Section 9-7-6 NMSA 1978 of the Department of Health Act, as amended; and the authority granted under Subsection D of Section 24-1-2, Subsection I of Section 24-1-3, Subsection R of Section 24-1-3 and 24-1-5 NMSA 1978 of the Public Health Act, as amended.

[7.10.2.3 NMAC - N, 3/1/2016]

7.10.2.4 DURATION: Permanent.

[7.10.2.4 NMAC - N, 3/1/2016]

7.10.2.5 EFFECTIVE DATE: March 1, 2016, unless a later date is cited at the end of a section.

[7.10.2.5 NMAC - N, 3/1/2016]

7.10.2.6 OBJECTIVE:

A. To encourage the establishment and maintenance of freestanding birth centers which provide quality care within a safe home like environment for mothers and infants.

B. To establish minimum standards for licensing of freestanding birth centers that provide birthing services different from, and outside the acute care hospital setting, while promoting safety and quality care for mothers and infants.

C. To monitor freestanding birth center compliance under these regulations through surveys and to identify any facility areas in which could be dangerous or harmful.

[7.10.2.6 NMAC - N, 3/1/2016]

7.10.2.7 DEFINITIONS:

A. "AABC" means American association of birth centers.

B. "Administrator" means the person who is delegated the administrative responsibility for interpreting, implementing, and applying policies and procedures at the birth center. The administrator is responsible for establishing and maintaining safe and effective management, control and operation of the facility and all of the services provided at the facility, including fiscal management. The administrator must meet the minimum administrator qualifications in these regulations.

C. "Applicant" means the individual or legal entity that applies for a license. If the applicant is a legal entity, then the individual signing the license application on behalf of the legal entity must have written legal authority from the legal entity to act on its behalf and execute the application. The license applicant must be the legal owner of the facility.

D. "Apprentice midwife" means an individual as defined in and licensed under 16.11.3 NMAC, as amended, and currently in good standing.

E. "ACNM" means the American college of nurse midwives.

F. "Basic life support" (BLS) means training and current certification in adult cardiopulmonary resuscitation equivalent to American heart association class C basic life support and in emergency treatment of a victim of cardiac or respiratory arrest through cardiopulmonary resuscitation and emergency cardiac care.

G. "Birth assistant" means a staff person over the age of 18 who is capable of recognizing complications and who can care for the mother and infant by performing normal postpartum and newborn care. At a minimum, a birth assistant must be trained and have current certifications in BLS and neonatal resuscitation program (NRP) and can only function under the direct supervision of a licensed provider immediately available on site.

H. "Birth center" (BC) means a freestanding birth center licensed by the state for the primary purpose of performing low-risk deliveries that is not a hospital, attached to a hospital or in a hospital, and where births are planned to occur away from the mother's residence following a low-risk pregnancy.

I. "Birth room" or "birthing room" means a private room of sufficient size to accommodate a client in active labor with the equipment and personnel necessary to assist the mother in a safe birth and in full compliance with the minimum standards in these regulations. Any facility with four or more birthing rooms must also comply with the birthing room and center requirements in the current edition of the facility guidelines institute, guidelines for design and construction, specific requirements for freestanding birth centers.

J. "CABC" means the commission for the accreditation of birth centers.

K. "Certified nurse midwife" means a licensed individual educated in the two disciplines of nursing and midwifery as defined and licensed under 16.11.2 NMAC, as amended, and currently in good standing.

L. "Certified nurse practitioner" means a registered nurse as defined and licensed under the Nursing Practice Act, Section 61-3-23.2 NMSA 1978, as amended, and related regulations and is currently in good standing.

M. "CLIA" means Clinical Laboratory Improvement Amendments of 1988 as amended.

N. "Client" means any person who receives care, including a mother, infant or newborn, at a freestanding birth center.

O. "Compliance" means the facility's adherence to these regulations, as well as any and all other applicable state and federal statutes and regulations. Compliance violations may result in sanctions, civil monetary penalties and revocation or suspension of the facility license.

P. "Deficiency" means a violation of or failure to comply with any provision(s) of these regulations.

Q. "Department" means the New Mexico department of health.

R. "Employee" means any person who works at the facility and is a direct hire of the owner or management company, if applicable.

S. "External quality committee" means the members of the internal quality committee and an external peer reviewer or a clinical consultant and any other facility healthcare partners, as available.

T. "Facility" means the physical premises, building(s) and equipment where the freestanding birth center services are provided, whether owned or leased and which is licensed pursuant to these regulations.

U. "Incident" means any known, alleged or suspected event of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.

V. "Incident management system" means the written policies and procedures adopted or developed by the licensed health facility for reporting abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.

W. "Incident report form" means the reporting format issued by the department for the reporting of incidents or complaints.

X. "Internal quality committee" means and includes the administrator and clinical director at a minimum. If the administrator and clinical director are the same person, another staff person with clinical experience must serve on the internal quality committee. Other staff at the facility may also serve on this committee as deemed appropriate.

Y. "License" means the document issued by the licensing authority pursuant to these regulations granting the legal right to operate a birth center for a specified period of time, at the physical premises, not to exceed one year.

Z. "Licensee" means the person(s) or legal entity that operates the physical premises and facility and in whose name the facility license has been issued and who is legally responsible for compliance with these regulations.

AA. "Licensed midwife" means a licensed individual as defined and licensed under 16.11.3 NMAC, as amended, currently in good standing.

BB. "Licensed practical nurse" means a licensed individual as defined and licensed under the Nursing Practice Act, Section 61-3-19 NMSA 1978, as amended, currently in good standing.

CC. "Licensing authority" means the New Mexico department of health.

DD. "Low risk pregnancy" means a pregnancy that is determined by documented medical history, risk assessment, and prenatal care that reasonably predicts an outcome of a normal and uncomplicated labor and birth.

EE. "Management company" means the legal entity that manages the facility, if different from the legal owner of the facility.

FF. "Midwife" means a licensed individual authorized to practice midwifery in New Mexico as defined and licensed under 16.11.2 NMAC, as amended, or 16.11.3 NMAC, as amended, currently in good standing.

GG. "NFPA" means the national fire protection association which sets codes and standards for building fire safety.

HH. "NMSA" means the New Mexico Statutes Annotated 1978 compilation and all subsequent amendments, revisions and compilations.

II. "Neonatal resuscitation program" (NRP) means training and current certification in both the NRP module on medications and the module on intubation using an endotracheal tube (ET) or laryngeal mask airway (LMA) or both, endorsed by American academy of pediatrics or the American heart association.

JJ. "Quality assurance" means the licensed health care facility's on-going comprehensive self-assessment of compliance with these regulations and any and all other applicable statutes and regulations including, but not limited to,, the facility's own policies and procedures and incident investigations, documentation, reporting and reviewing of all alleged incidents of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents for study and improvement of the facility's organizational, administrative and preventative practices in employee training and reporting.

KK. "Quality improvement system" means a systematic approach to the continuous study and improvement of the efficacy of organizational, administrative and clinical practices to meet the needs of persons served, address any changing regulatory requirements and achieve the facility's mission, values and goals.

LL. "Physician" means a licensed individual, currently in good standing, authorized to practice medicine as defined and licensed under the New Mexico Medical Practice Act, Sections 61-6-1 to 61-6-34 NMSA 1978, as amended, and related regulations or osteopathic medicine as defined and licensed under Sections 61-10-1 to 61-10-22 NMSA 1978, as amended, and related regulations.

MM. "Physician's assistant" means an individual, currently in good standing, who is licensed and authorized to provide services to patients under the supervision and direction of a licensed physician under the Physician Assistant Act, Sections 61-6-7 to 61-6-10 NMSA 1978, as amended and related regulations, or is authorized and licensed to provide services to patients under the supervision and direction of a licensed osteopathic physician under the Osteopathic Physicians' Assistants Act, Sections 61-10A-1 to 61-10-7 NMSA 1978 as amended, and related regulations.

NN. "Plan of correction" (POC) means the plan submitted by the licensee or its representative(s) addressing how and when deficiencies identified through a survey or investigation will be corrected. A plan of correction is a public record once it has been approved by the regulatory authority and is admissible for all purposes in any adjudicatory hearing and all subsequent appeals relating to a facility license, including to prove licensee compliance violations or failures.

OO. "Policy" means a written statement that guides and determines present and future facility decisions and actions.

PP. "Premises" means all of the facility including buildings, grounds and equipment.

QQ. "Procedure" means the action(s) that must be taken in order to implement a written policy.

RR. "Registered nurse" means an individual, currently in good standing, who is licensed and authorized to provide nursing services under the Nursing Practice Act, Sections 61-3-1 to 61-3-30 NMSA 1978, as amended, and related regulations.

SS. "Scope of practice" means the procedures, actions, and processes that a healthcare practitioner is permitted to undertake under the terms of their professional license. The scope of practice is limited to that which the applicable law allows for specific education, training, experience and demonstrated competency.

TT. "Staff" means any person who works at the facility, and includes employees, contracted persons, independent contractors and volunteers who perform work or provide goods and services at the facility.

UU. "U/L approved" means approved for safety by the national underwriters laboratory.

VV. "Variance" means a written decision, made at the licensing authority's sole discretion, allowing a licensee and facility to deviate from a portion(s) or provision of these regulations for a specified time period not exceeding a year, providing the variance does not jeopardize the health, safety or welfare of the facility's clients, patients and staff and is not in violation of other applicable state and federal statutes and regulations.

WW. "Violation" means any and all actions or procedures by the facility or licensee that are not in compliance with these regulations and any and all other applicable state and federal statutes and regulations.

XX. "Waive" or "waiver" means a written decision, made at the licensing authority's sole discretion, to allow a birth center to refrain from complying with a portion(s) or provision of these regulations for a limited and specified time period not exceeding a year, providing the waiver does not jeopardize the health, safety or welfare of the facility's clients, patients and staff and is not in violation of other applicable state and federal statutes and regulations.
[7.10.2.7 NMAC - N, 3/1/2016]

7.10.2.8 STANDARD OF COMPLIANCE: The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may". "Shall" or "must" means mandatory compliance. "May" means permissive compliance. The words "adequate", "proper", and other similar words mean the degree of compliance that is generally accepted throughout the professional field by those who provide birthing services to the public in facilities governed by these regulations. However, if any other applicable statute or regulation requires mandatory or stricter compliance for birth center services than these regulations, the licensee and facility must comply with the more strict compliance requirements.
[7.10.2.8 NMAC - N, 3/1/2016]

7.10.2.9 FREESTANDING BIRTH CENTER SCOPE OF SERVICES:

A. General scope of services. Freestanding birth centers endorse the wellness care model by providing supportive care and using interventions only when medically necessary. Birth centers may provide women's health services including annual exams, contraception counseling, pre-conception counseling, sexually transmitted infection testing and treatment, prenatal care, birth services, and postpartum and newborn care following a normal, low risk pregnancy. The facility may offer other health services by licensed professionals working within the scope of their license providing the physical space used by the other services is clearly delineated and separate from the birth center services, the other services do not interfere with any birth center requirements, the facility complies with any applicable licensing regulations for the other services, and the department

is capable of determining the physical boundaries between the birth center facilities licensed under these regulations and other facilities, if licensed under other regulations.

B. Limitations on scope of services. Except in the event of an emergency, surgical procedures shall be limited to those normally performed during birth, but may include episiotomy and repair, other procedures for newborns, and well women's care but only if such procedures are performed by a licensed practitioner acting within the scope of the practitioner's license. Trials of labor after cesarean section (TOLAC) and vaginal birth after cesarean (VBAC) services shall only be performed at a freestanding birth center by a practitioner whose license authorizes this scope of practice.

C. Services not allowed and not to be performed at freestanding birth center. The following services shall not be performed in a freestanding birth center:

(1) general, regional or epidural anesthesia services;

(2) medications for cervical ripening, induction or augmentation of labor;

(3) operative vaginal forceps or vacuum or abdominal births; and

(4) abortions.

D. Geographic requirements.

(1) Freestanding birth centers shall be located within a maximum of 30 minutes normal driving time from a referral hospital. Reliable evidence of normal driving time must be provided.

(2) The department may, at its sole discretion, approve a variance for a freestanding birth center that is located more than 30 minutes normal driving time from a referring hospital, if the department finds that the health and safety of the birth center clients will not be adversely affected.

E. Additional requirements applicable to facilities with four or more birthing rooms. Any and all facilities with four or more birthing rooms shall comply with all of these regulations and also with all applicable requirements in the current edition of the facility guidelines institute's guidelines for design and construction, specific requirements for freestanding birth centers.

[7.10.2.9 NMAC - N, 3/1/2016]

7.10.2.10 LICENSE REQUIRED: A freestanding birth center facility shall not be operated without a license issued by the department. Any freestanding birth center or facility operating after the effective date of these regulations, must be licensed under these regulations. Any facility providing the services described in these regulations after the effective date of these regulations, shall apply for a freestanding birth center license within 180 days. Any unlicensed freestanding birth center that has not applied for a license, may only continue to operate without a license for 180 days from the effective date of these regulations. A freestanding birth center licensed under these regulations shall not assert, represent, offer, provide or imply that the facility is or may render care or services other than the services it is permitted to render under these regulations and within the scope of all applicable professional license(s). If an unlicensed freestanding birth center is found to be providing services for which a license is required under these regulations, the secretary may issue a cease-and-desist order, to protect human health or safety or welfare. The licensed facility may request a hearing that shall be held in the manner provided under these regulations and all other applicable regulations.

[7.10.2.10 NMAC - N, 3/1/2016]

7.10.2.11 INITIAL LICENSURE PROCEDURES: These regulations should be thoroughly understood and used by the applicant, when applying for the initial freestanding birth center license. The applicant for an initial facility license under these regulations must follow these procedures when applying for a license.

A. Notification and letter of intent: The owner shall advise the licensing authority of its intent to open a freestanding birth center pursuant to these regulations by submitting a letter of intent. The letter of intent must be on the applicant's letterhead and signed by a person with authority to make legal decisions for the owner and the facility and at a minimum, include the following:

(1) the name of facility;

(2) the name of the legal owner and licensee and the type of legal entity under which the facility shall be owned;

(3) the name of the management company, if any;

(4) the type of facility license requested;

(5) the anticipated number of clients to be served;

(6) the number of birthing rooms in the proposed facility;

(7) the physical address of facility including building name or suite number;

(8) the mailing address, if different from physical address;

(9) the contact name(s), address, e-mail address, and telephone number(s);

(10) the anticipated payers and sources of reimbursement; and

(11) a list of all services, medical and non-medical, to be provided at the facility location which is requesting the license.

B. License application and fees: After review by the department of the letter of intent for general compliance with these regulations and verification that an application is appropriate under these regulations, the owner shall be required to complete a license application on a form provided by the department. Prior to any construction, renovation or addition to an existing building and after review and approval of the letter of intent by the department, the applicant must submit to the licensing authority an application form provided by the department, fully completed, printed or typed, dated, signed, and notarized accompanied by the required fee. If electronic filing of license applications is available at the time of application, the applicant will be required to follow all electronic filing requirements, and may forgo any notary requirements, if specifically allowed under the applicable electronic filing statutes, regulations and requirements. Current fee schedules will be provided by the licensing authority. The department reserves the right to require additional documentation to verify the identity of the applicant in order to verify whether any federal or state exclusions may apply to the applicant. Fees must be paid in the form of a certified check, money order, personal, or business check, or electronic transfer (if available), made payable to the state of New Mexico, and are non-refundable.

C. Existing facility and building plans: As part of the initial license application, the applicant must also attach to the application and submit to the department, a set of building plans which includes all of the information required by these rules, accompanied by proof of zoning approvals by the

applicable building authority. The existing facility building plans must be of professional quality, on substantial paper measuring at least 24" x 36", and drawn to an accurate scale of one-eighth inch to one foot. The plans for existing construction must include sufficient information for the department to make a compliance determination and at a minimum:

(1) floor plans showing proposed use of each room, (e.g., waiting room, examination room, office, etc.);

(2) interior dimensions of all rooms;

(3) one building or wall section showing an exterior and interior wall construction section including the material composition of the floor, wall, and ceiling/roof, and the finishes, (e.g., carpet, tile, gypsum board with paint, or wood paneling);

(4) door locations and types (swing) and sizes of all doors, including width, height and thickness;

(5) location of all sinks, tubs and showers;

(6) location and operation of windows including size and type;

(7) location and dimension of all level changes within and outside the building, (e.g., steps or ramps);

(8) location of fire extinguishers, heat and smoke detectors, and operational elements of alarm systems;

(9) location of heating units, furnaces, hot water heaters, and fuel type and source;

(10) all heating, ventilating and air conditioning/cooling systems;

(11) location of the building on a site/plot plan to determine surrounding conditions, include all steps, ramps, parking areas, handicapped spaces, walks and any permanent structures, including construction materials; and

(12) all existing construction, new construction, remodeled portions, and proposed additions, must be delineated on the plans, clearly indicating where existing construction ends and proposed remodeling and new construction begins.

D. Remodeling, new and proposed construction: If the proposed facility includes any remodeling, renovations or additions to an existing building or new construction of any type, building plans and specifications covering all portions of the proposed work delineating all existing construction and all new and proposed construction shall be attached to the application and submitted to the department for review and approval as part of the application. Building plans will be reviewed by the department for compliance with current licensing regulations, building and fire safety codes. If the facility's building plans are approved by the department and local building officials have issued a construction permit, construction may begin. This provision is an ongoing requirement and applies to, and includes any and all construction at the facility, which occurs before and after issuance of the initial license. This provision does not generally apply to maintenance and repair. However, if the maintenance or repair impacts or alters any of the facility requirements under these regulations, the applicant or licensee must notify the department and verify ongoing compliance with these regulations. The department shall not be liable for any costs or damages incurred by the applicant relating to construction in the event the applicant incurs costs or damages in order to comply with these regulations or to obtain a license under these regulations. For all new and proposed construction, the applicant or licensee must submit for approval by the department before construction begins, the following:

(1) one copy of building plans and specifications, including a site plan, that are of professional quality, on substantial paper measuring at least 24" x 36" and drawn to an accurate scale of one-eighth inch to one foot;

(2) the building plans must be drawn to scale and show the general arrangement of the buildings, and include a room schedule, show fixed equipment for each room, and list room numbers, together with all other pertinent explanatory information addressing the requirements in applicable regulations;

(3) any changes in the approved building plans affecting compliance with these rules shall be shown on the approved plans and shall be submitted to the department for approval before construction is undertaken;

(4) any and all completed new construction shall comply with the plans and specifications approved by the department prior to construction, these rules, and any and all other applicable rules and codes; and

(5) any of the department's approval(s) shall not waive any other rules or other applicable building and code requirements enforceable by other authorities.

E. Initial survey phase: Upon receipt of a properly completed application with all necessary supporting documentation, an initial life safety survey of the proposed facility will be scheduled by the licensing authority. Upon completion of the initial life safety survey and determination that the facility is in compliance with all life safety and building requirements, the licensing authority may issue a temporary license pending completion of its initial health survey or an annual license if allowed or applicable under these regulations. [7.10.2.11 NMAC - N, 3/1/2016]

7.10.2.12 ADDITIONAL DOCUMENTS REQUIRED WITH LICENSE APPLICATION: The department reserves the right to require an applicant to provide any and all additional documents, as part of its license application, in order for the department to determine whether the applicant and the facility are in full compliance with these regulations, as well as any and all other applicable statutes and regulations. At a minimum, additional documents required to be attached to the initial license application, include, but are not limited to:

A. Building approvals: The applicant must submit all building approvals required for the facility to operate in the jurisdiction in which it is located, including, but not limited to,,:

(1) written building approvals and certificates of occupancy from the appropriate authority (state, city, county, or municipality) for business occupancy; and

(2) written fire safety approvals from the fire safety authority having jurisdiction.

B. Environment approvals: If applicable or required, the applicant must provide written approval from the New Mexico environment department for the following:

(1) private water supply;

(2) private waste or sewage disposal; and

(3) ultrasound equipment.

C. Board of pharmacy approvals: A copy of facility's drug permit issued by the state board of pharmacy must be provided.

D. Program outline: The applicant must submit with its license application a program outline consistent

with these regulations which includes at a minimum, the following information:

(1) a list of all services and the scope of those services to be provided by the proposed facility;

(2) projected number of clients to be served monthly;

(3) a list of staffing and personnel requirements and duties to be performed;

(4) a list of all services that will be contracted or arranged with any other health providers including ambulance services, admitting hospitals, consultation with medical practitioners, laboratory work and equipment providers;

(5) the number of examination rooms, birth rooms, family rooms and other rooms for diagnostic or other use including, but not limited to,, ultrasound, laboratory, clean linen storage and waste disposal;

(6) an organizational structure diagram or chart including the administrator, advisory body or board of directors, if any, staff, clinical director, internal quality committee and external quality committee; and

(7) quality improvement systems and quality assurance processes.

E. Policies and procedures: The applicant must submit with its license application a copy of the facility's policies and procedures which must comply with these regulations.

[7.10.2.12 NMAC - N, 3/1/2016]

7.10.2.13 LICENSE TYPES, VARIANCES & WAIVERS:

A. Temporary license: The licensing authority may, at its sole discretion, issue a temporary license to a new freestanding birth center before clients are admitted or for facilities that existed prior to enactment of these regulations, provided that the freestanding birth center has submitted a license application, supporting documents, has met all of the applicable life safety code requirements, and its program, policies, and procedures have been reviewed for compliance with these regulations. A temporary license is not guaranteed under these regulations and shall be limited and restricted to:

(1) a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies;

(2) no more than two consecutive temporary licenses shall be issued in accordance with applicable statutes and regulations;

(3) the facility being allowed to accept clients and provide care services, subject to any requirements and restrictions attached to the temporary license;

(4) a finding that the applicant is qualified and in full compliance with applicable life safety code requirements; and

(5) any determination of compliance or noncompliance for a temporary license or initial license shall be made at the licensing authority's sole discretion based upon the health, safety, or welfare of the facility's clients, patients and staff and proof by the applicant that it is not in violation of other applicable state and federal statutes and regulations.

B. Annual license: An annual license is issued for a one-year period to a freestanding birth center facility which has met all requirements of these regulations. If a temporary license is issued, once the department has issued a written determination of full compliance with these regulations, an annual license will be issued with the renewal date of the annual license based upon the initial date of the first temporary license.

C. Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator or when there is a change of name for the facility, but an amended license shall only be issued if the administrator is not an owner. If the administrator is also the owner, a new license application must be submitted as provided in this regulation. The amended license application must:

(1) be on a form, or filed electronically if available, as required by the licensing authority;

(2) be accompanied by the required fee for the amended license; and

(3) be submitted within 10 working days of the change.

D. Variances and waivers: At the licensing authority's sole discretion, an applicant or licensee may be granted variances and waivers of these regulations, provided the granting of such variance or waiver shall not jeopardize the health, safety or welfare of the facility's clients, patients and staff and is not in violation of other applicable state and federal statutes and regulations. All variances and waivers shall be in writing attached to the license and shall be limited to the term of the license. Upon renewal of a license, any variances and waivers shall only be extended or continued at the sole discretion of the licensing authority providing such variance or waiver shall not jeopardize the health, safety or welfare of the facility's clients, patients and staff and is not in violation of other applicable state and federal statutes and regulations at the time of renewal. Variances and waivers are non-transferrable and shall not be granted indefinitely.

[7.10.2.13 NMAC - N, 3/1/2016]

7.10.2.14 LICENSE RENEWAL:

A. Licensee must submit a renewal application, electronically, if available, or on forms authorized by the licensing authority, along with the required license fee at least 30 days prior to expiration of the current license. The applicant shall certify that the facility complies with all applicable state and federal regulations in force at the time of renewal and that there has been no new construction or remodeling or additions which differ from the plans provided and reviewed with the prior license application. If there has been any construction or remodeling or additions to the facility since issuance of the last license, and the construction has not been previously approved, the license renewal applicant shall be required to comply with all construction documentation requirements under these regulations when applying for the license renewal. The department reserves the right to require that a renewal applicant provide any and all additional documents, including any necessary proof of current compliance, as part of its license renewal application in order for the department to determine whether the applicant and the facility are in full compliance with these regulations.

B. Upon receipt of the renewal application and the required fee, the licensing authority will issue a new license effective the day following the date of expiration of the current license, if the facility is in substantial compliance with these regulations and any and all other applicable state and federal regulations.

C. If the existing license expires and the licensee has failed to submit a renewal application, the department may charge the applicant a late fee of $100 for each month or portion of a month that the facility continues to operate without a license providing that during such time the facility remains in full compliance with these regulations. If the facility does not renew its license and

continues to operate without paying late fees and without being in full compliance with these regulations, the facility shall cease operations until it obtains a new license through the initial licensure procedures, and shall still be required to pay late fees. Under Section 24-1-5 NMSA 1978, as amended, no freestanding birth center shall be operated without a license and any such failure may subject the operators to various sanctions and legal remedies, including at a minimum the imposition of civil monetary penalties.

D. It shall be the sole responsibility and liability of the licensee to be aware of the status, term and renewal date of its license. The licensing authority shall not be responsible to notify the facility of the renewal date or the expiration date of the facility's license.

E. After issuance of the initial license, if there has been no construction or remodeling or additions to the facility and the facility is in substantially the same condition as the plans on file with the department, the facility may be issued a license renewal based upon its accreditation status if it has been fully accredited by an approved national accrediting organization such as, the commission for the accreditation of birth centers or its successor, and the facility maintains its accreditation status throughout the course of the license term. The licensee shall be responsible for providing verifiable evidence of accreditation status with its license renewal application and any time during the term of its license upon request. The department, at its sole discretion, reserves the right to require additional documentation of compliance with these regulations and all applicable state and federal statutes and regulations by the licensee at the time of license renewal, even if the facility is accredited by an approved national accrediting organization.

[7.10.2.14 NMAC - N, 3/1/2016]

7.10.2.15 POSTING OF LICENSE: The facility's license must be posted in a conspicuous place on the licensed premises in an area visible to the public.

[7.10.2.15 NMAC - N, 3/1/2016]

7.10.2.16 NON-TRANSFERABLE RESTRICTION ON LICENSE:

A. A license granted under these regulations is not transferable to any other owner, whether an individual or legal entity, or to another location. The department shall not guarantee or be liable for or responsible for guaranteeing the transfer of the license to any other owner or other location. The existing license shall be void and must be returned to the licensing authority when any one of the following situations occurs:

(1) any ownership interest in the facility changes;

(2) the facility changes location;

(3) the licensee of the facility changes; or

(4) the facility discontinues operation.

B. Any owner or applicant wishing to continue operation of an already licensed facility must submit a new application for an initial license in accordance with these regulations at least 30 days prior to the anticipated change and shall not be guaranteed issuance of a license under the same terms and conditions of an existing license. Failure by any owner or new owner to apply for a new license under these conditions, while continuing to operate under these regulations, shall be considered a violation of these regulations and consent to the imposition of late fees, sanctions or other actions for operating without a license, allowed under these regulations and all other applicable statutes and regulations.

[7.10.2.16 NMAC - N, 3/1/2016]

7.10.2.17 AUTOMATIC EXPIRATION OR TERMINATION OF LICENSE: An existing license shall automatically expire at midnight on the day indicated on the license, unless it is renewed sooner or it has been suspended or revoked. If a facility discontinues operation, is sold, leased or otherwise changes any ownership interest or changes location, the existing license shall automatically expire at midnight on the date of such action. Failure by any owner or new owner to apply for a renewal or new license, while continuing to operate under these regulations, shall be considered a violation and consent to the imposition of late fees, sanctions or other actions for operating without a license, allowed under these regulations and all other applicable statutes and regulations.

[7.10.2.17 NMAC - N, 3/1/2016]

7.10.2.18 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING: If immediate action is required to protect human health and safety, the licensing authority may act in accordance with Section 24-1-5 NMSA 1978, as amended, and suspend a license pending a hearing, provided such hearing is held within five working days of the suspension, unless waived by the licensee.

[7.10.2.18 NMAC - N, 3/1/2016]

7.10.2.19 GROUNDS FOR DENIAL OF INITIAL OR RENEWAL LICENSE APPLICATION, SUSPENSION OR REVOCATION OF LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: An initial license application or a renewal license application may be denied, or an existing license may be revoked or suspended, or intermediate sanctions or civil monetary penalties may be imposed, after notice and opportunity for a hearing, for any of the following:

A. failure to comply with any provision of these regulations;

B. failure to allow access to the facility and survey(s) by authorized representatives of the licensing authority;

C. allowing any person to work at the facility while impaired physically or mentally or under the influence of alcohol or drugs in a manner which harms the health, safety or welfare of the clients, newborns, staff or visitors;

D. allowing any person, subject to all applicable statutes and regulations, to work at the facility if that person is listed on the employee abuse registry or considered an unemployable caregiver under the Caregivers Criminal History Screen Act, as amended, and related regulations, as amended or has a felony conviction for:

(1) homicide;

(2) trafficking controlled substances;

(3) kidnapping, false imprisonment, aggravated assault or aggravated battery;

(4) rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure or other related sexual offenses;

(5) crimes involving adult abuse, neglect or financial exploitation;

(6) crimes involving child abuse or neglect;

(7) robbery, larceny, burglary, fraud, extortion, forgery, embezzlement, credit card fraud or receiving stolen property; or

(8) an attempt, solicitation or conspiracy involving any of the felonies in this subsection.

E. misrepresentation or falsification of any information on application forms or on other documents

provided to the licensing authority or used by the licensing authority in granting or renewing a license;

F. repeat violations of these regulations or discovery of repeat violations during survey(s); or

G. failure to provide the required care and services specified in these regulations or providing care and services beyond the scope of the facility's license at the facility;

H. **t**he list above shall not limit the department from imposing sanctions and civil monetary penalties under all applicable statutes, regulations and codes.

[7.10.2.19 NMAC - N, 3/1/2016]

7.10.2.20 HEARING PROCEDURES: Hearing procedures for an administrative appeal of an adverse action taken by the department against a facility's license will be held in accordance with applicable rules relating to adjudicatory hearings, including, but not limited to,,, 7.1.2 NMAC, as amended. A copy of the above regulations will be furnished at the time an adverse action is taken against a facility's license by the licensing authority, if the regulations cannot be obtained from a public website.

[7.10.2.20 NMAC - N, 3/1/2016]

7.10.2.21 FACILITY SURVEYS:

A. Application for licensure, whether initial or renewal, shall constitute permission for unrestricted entry into and survey of a facility by authorized licensing authority representatives at times of operation during the pendency of the license application, and if licensed, during the licensure period.

B. Surveys may be announced or unannounced at the sole discretion of the licensing authority. If, at the time of a facility survey, a client is in labor, birthing, or immediately postpartum, the survey may be rescheduled at the sole discretion of the licensing authority without penalty to the facility.

C. Upon receipt of a notice of deficiency from the licensing authority, the licensee or his/her representative shall be required to submit a plan of correction to the licensing authority within 10 working days stating how the facility intends to correct each violation noted and the expected date of completion. All plans of correction for state or federal deficiencies, if any, shall be disclosed in compliance with applicable state or federal statutes and regulations. A state plan of correction is not confidential once it has been approved and is admissible for all purposes in any adjudicatory hearing and all subsequent appeals relating to a facility license, including to prove licensee compliance violations.

D. The licensing authority may at its sole discretion accept the plan of correction as written or require modifications of the plan by the licensee.

[7.10.2.21 NMAC - N, 3/1/2016]

7.10.2.22 REPORTING OF INCIDENTS: All facilities licensed under these regulations must comply with all incident intake, processing, training and reporting requirements under these regulations, as well as with any and all other applicable statutes and regulations. All facilities shall report to the licensing authority any serious incidents or unusual occurrences which have threatened, or could have threatened the health, safety and welfare of the clients, including, but not limited to,,:

A. fire, flood or other man-made or natural disasters including any damage to the facility caused by such disasters and any incident which poses or creates any life safety or health hazards;

B. any outbreak of contagious diseases and diseases dangerous to the public health;

C. any human errors by staff and employees which may or has resulted in the death, serious illness, or physical impairment of a client or newborn or staff; and

D. abuse, neglect, exploitation, injuries of unknown origin and other reportable incidents in accordance with 7.1.13 NMAC, as may be amended from time to time.

[7.10.2.22 NMAC - N, 3/1/2016]

7.10.2.23 QUALITY ASSURANCE, QUALITY IMPROVEMENT SYSTEM, INTERNAL QUALITY COMMITTEE, EXTERNAL QUALITY COMMITTEE AND POLICIES AND PROCEDURES: Each facility shall establish and maintain policies and procedures for quality assurance and quality improvement systems, as well as an internal quality committee and an external quality committee.

A. Policies and procedures: The administrator shall establish written policies and procedures which govern the facility's complete operation. The facility shall ensure that these policies are adopted, administered and enforced to provide quality health services in a safe environment. At a minimum, the facility's written policies and procedures shall include how the facility intends to comply with all requirements of these regulations and address:

(1) the facility organization including the legal entity or organization which owns the facility, any management companies or managers which manage the facility, the identity and credentials of the administrator responsible for establishing lines of responsibility and accountability for both licensed and non-licensed staff, and the administrator's responsibility to direct employees or contractually retain qualified individuals providing fiscal management and all operations in the facility, as well as maintaining records of disclosure of conflicts of interest and all ownership interests and controlling parties;

(2) the facility administration including designation of an administrator with authority, responsibility, and accountability for overall administration and operation, including plans for the administrator's absence;

(3) the maintenance of the facility, equipment and supplies including sterilization and disinfection of supplies, equipment and instruments; cleaning of birthing room after each use; inspection and maintenance of emergency equipment; maintenance of emergency supplies; maintenance, upkeep and cleaning of the building(s) and equipment; fire and emergency evacuation procedures; and proper disposal of waste liquids used for cleaning contaminated areas;

(4) quality of care and services including appropriate and inappropriate admission criteria; client rights; client risk assessment; administration and preparation of drugs; quality assurance and performance improvement programs; referral of clients for additional services including, but not limited to,, laboratory and sonography; transfer of clients to a hospital; ambulance transfer services; emergency procedures and resuscitative techniques; aseptic techniques; infectious waste and biohazard disposal in accordance with all applicable statutes and regulations; and safe handling of the placenta for families requesting to keep the placenta;

(5) staffing and personnel including written job descriptions for all staff with necessary

qualifications consistent with these rules; minimum staffing and staff qualifications; and staff development and evaluation;

(6) maintenance of the client health record including protection of client confidentiality and privacy as required by law; secure release of medical information and records; and safe handling and storage of client records including appropriate document destruction procedures; and

(7) research procedures for any research being conducted at the facility in compliance with these regulations.

B. Internal quality committee: The internal quality committee is comprised at a minimum of the administrator and clinical director. If the administrator and the clinical director are the same person, another staff person with clinical experience shall be made a member of this committee. This committee shall establish and implement quality assurance and quality improvement systems monitoring and promoting quality care to clients through reviews that include chart review, data collection, client satisfaction surveys, and other program monitoring processes; data analyses; identification of areas for improvement; intervention plans, including action steps, responsible parties, and response time; and, evaluation of the effectiveness of interventions. The internal quality committee shall at a minimum, implement a thorough chart review process, as defined in these regulations, which considers and reviews outcome data analysis, targeted concern and improvement areas, client satisfaction surveys, and evidence based research to identify necessary quality improvement areas and processes. When areas of concern or potential problems are identified by the committee, the facility shall act as soon as possible to avoid and prevent risks to clients. The internal quality committee shall take and maintain meeting minutes. The internal quality committee shall, at a minimum, meet or convene:

(1) within 72 hours of every emergent or sentinel event to conduct an initial review and follow-up; if the internal quality committee consists of less than three people, the external quality committee shall convene to review emergent and sentinel events;

(2) monthly to document any significant events and any necessary quality care improvement steps to be applied to future events;

(3) quarterly for a detailed chart review, as provided in these regulations, of a minimum of five charts consisting of a minimum of one chart for each midwife and physician practicing at the facility; charts of all labor, postpartum, and newborn transfers; Apgar scores less than seven at five minutes; hemorrhage greater than 1000 ml; and any other significant problems encountered within the quarter;

(4) annually for review of policies and procedures, including, but not limited to,,:

(a) environment of care;

(b) testing and maintenance of equipment according to manufacturer's recommendations;

(c) housekeeping procedures;

(d) infection control procedures;

(e) privacy and security processes;

(f) compliance with policies and procedures for all emergency drills, including, but not limited to,,, fire, maternal/newborn emergencies, power failures, and natural disasters;

(g) evaluation of maintenance policies and procedures for heat, ventilation, emergency lighting, waste disposal, water supply, laundry, and nourishment station;

(h) annual employee performance evaluations;

(i) clinical practice guidelines; and

(5) submission of an annual quality report to the external quality committee.

C. External quality committee: The facility shall establish an external quality committee which includes the members of the internal quality committee, an external peer reviewer or a clinical consultant and other healthcare partners, if available. The external quality committee shall meet at least quarterly and perform an in-depth peer review case study on a minimum of five charts which include at a minimum one case for each midwife and physician practicing at the facility. The external quality committee shall also review the care of individual clients, targeted types of clients, and appropriateness of the clinical practitioner's judgment and management of the case under the facility's standards of care and policies, and make recommendations for care improvements. The external quality committee shall also discuss relevant evidence based research and make recommendations relating to clinical practice guidelines to improve quality of care.

[7.10.2.23 NMAC - N, 3/1/2016]

7.10.2.24 RISK ASSESSMENT, CLIENT ACCEPTANCE AND LABOR ADMISSION CRITERIA: All licensed facilities shall follow and maintain written clinical practice guidelines which address, at a minimum, eligibility for care, on-going eligibility, medical consultation, and transfer criteria in accordance with the scope of practice authorized under each practitioner's individual license(s) to be reviewed and updated by the internal quality committee at least annually.

A. Risk assessment: A licensed practitioner shall make risk assessments of all clients that at a minimum include:

(1) an initial assessment which documents the general health and eligibility of a potential client and which includes a detailed medical, social and family history, a physical examination, and routine prenatal labs; the assessment may also include ultrasounds to determine whether the client meets the criteria for the facility's scope of care;

(2) completing, maintaining, and documenting an initial risk assessment and an on-going risk assessment in the client record which include compliance with admission criteria prior to client acceptance and throughout the pregnancy with the clinical director making the final determination of each client's risk;

(3) if a client before 32 weeks gestation has failed to register for freestanding birth center care and has not received prenatal care, the client shall not be accepted for care at the facility unless the client obtains a medical consultation outside of the facility, meets all other eligibility criteria, and a written, signed exception is made by the clinical director on a case-by-case basis;

(4) clear documentation of referrals, consultations and transfers to other providers for ineligible clients or medical transfers;

(5) assessing each client's risk status on admission in labor and throughout labor for continuation of services;

(6) whether the facility will have adequate space and sufficient staff to support the client newborn during labor, birth and

postpartum;

(7) written criteria for antepartum, intrapartum, postpartum and newborn acceptance and transfer to a hospital which delineates the transfer process from the facility to an accepting hospital; and

(8) limitations on the number of active labor clients at the facility to the number of birth rooms available at the facility.

B. Ineligibility for admission: If any of the following conditions exist, birth at the facility shall be considered inappropriate or improper:

(1) breech or non-vertex presentation at labor and delivery;

(2) gestation less than 37 weeks or greater than 42 weeks;

(3) multiple gestation;

(4) medication controlled gestational diabetes mellitus; or

(5) vaginal birth after cesarean (VBAC) candidates with more than one previous cesarean section, previous incision that is not low transverse, placenta location, anterior and low-lying over the old scar.

[7.10.2.24 NMAC - N, 3/1/2016]

7.10.2.25 CLIENT RIGHTS: All facilities licensed pursuant to these regulations shall support, protect, and respect clients' rights. Facility staff shall receive training on client rights and demonstrate understanding and competence in the policies and procedures regarding client rights. Client rights will be posted or made available to facility clients in English or their preferred language. The method by which a client may register a complaint against the facility will be posted or otherwise made available to clients. The facility shall have and enforce policies and procedures which guarantee:

A. the right to equal service, regardless of race, gender, gender identity, religion, ethnic background, sexual orientation, education, social class, physical or mental handicap, or economic status;

B. the right to considerate, courteous and respectful care from all staff;

C. the right to complete information using terms the average client can reasonably be expected to understand;

D. the right to informed consent, full discussion of risks and benefits prior to any invasive procedure, except in an emergency, and advice regarding alternatives to the proposed procedure(s);

E. the right to receive a written list of all services available, service costs and advanced notice of any changes;

F. the right to receive care that is consistent with current scientific evidence about benefits and risks;

G. the right for non-English speaking clients to obtain assistance in interpretation;

H. the right to know the names, titles, professions and specific types and licenses held by the facility staff to whom the client speaks to and from whom services or information are received;

I. the right to refuse examinations and procedures to the extent permitted by law and to be informed of the health and legal consequences of any refusal;

J. the right of access to the client's personal health records;

K. the right of respect for the client's privacy;

L. the right of confidentiality of the client's personal health records as provided by law;

M. the right to expect reasonable continuity of care within the scope of services and staffing;

N. the right to have the client's civil rights, cultural background and religious opinions respected;

O. the right to present complaints to the management of the facility without fear of reprisal; and

P. the right to examine and receive a full explanation of any charges made by the facility regardless of source of payment.

[7.10.2.25 NMAC - N, 3/1/2016]

7.10.2.26 CLIENT HEALTH RECORD: The facility shall maintain client health records in a legible, uniform, complete and accurate format that provides continuity and documentation of maternal and newborn information which is readily accessible to health care practitioners, while protecting confidentiality, using a system that allows for reliable and safe storage, retrieval and loss prevention. The facility must use a record form appropriate for use by the practitioners in the facility which contains the required information necessary for transfer to an acute care maternal and newborn hospital.

A. Record contents: Each licensed facility must maintain a medical record for each client which may be in a paper or electronic format but which can be easily accessible, copied, provided, reviewed and transported in the event of any emergency or transfer. Every record must be accurate, legible and promptly completed. At a minimum, facility health records for each client must include written documentation of the following:

(1) client demographics;

(2) client consent forms;

(3) pertinent medical, social, family, reproductive and nutritional history;

(4) a list of medications that are currently prescribed for the client, including any self-administered over-the-counter medication or neutraceuticals, including dose of medication, route of administration, and frequency of use;

(5) allergy list;

(6) initial physical exam;

(7) initial and on-going risk assessment and status;

(8) laboratory, radiology and other diagnostic reports;

(9) assessment of the health status and health care needs of the client;

(10) evidence of continuous prenatal care including progress notes;

(11) evidence of prenatal educational resources;

(12) labor and birth summary;

(13) postpartum care with evidence of follow-up within 48 hours of birth;

(14) newborn care and follow-up;

(15) appropriate referral of ineligible clients and documentation of transfer of care;

(16) documentation of any consultations, special examinations and procedures;

(17) discharge summary and applicable instructions to the client;

(18) list of staff present during labor, birth and postpartum;

(19) evidence that client rights have been provided to each client; and

(20) consent form for participation in research signed by the client, if applicable.

B. Client records maintenance:

(1) current client records shall be maintained on-site and stored in an organized, accessible and permanent manner, with copies easily accessible for review, transfers or in an emergency;

(2) the facility shall have in place policies and procedures in compliance with applicable law, for maintaining and ensuring the confidentiality of client records, which include the authorized release of information from the client records; and the retention and transfer of client records at closure or ownership changes;

(3) non-current client records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five years from the date of discharge and be readily available within 24 hours of request; if, any other applicable statutes or regulations require a longer term of record retention than five years, the longer term shall apply to the facility.

C. Chart review: At a minimum, a chart review performed by the internal quality committee shall consider written documentation of:

(1) appropriateness of admissions and continuation of services;

(2) complete client demographic information;

(3) signed informed consent(s);

(4) appropriate referral of ineligible clients;

(5) continuous prenatal visits, beginning no later than 32 weeks;

(6) continuous risk assessment throughout prenatal care and for admission in labor;

(7) appropriate maternal and newborn follow-up after birth;

(8) appropriateness of diagnostic and screening procedures;

(9) complete initial history;

(10) complete initial physical exam;

(11) complete prenatal labs and screenings;

(12) appropriateness of medications prescribed, dispensed or administered;

(13) documentation of medical consultation, if indicated;

(14) appropriate identification and management of complications;

(15) appropriate transfer of care for maternal/fetal/newborn indications;

(16) compliance with these rules;

(17) compliance with policies, procedures and clinical practice guidelines for maternal and fetal assessment during labor and postpartum;

(18) compliance with evidence based standards of practice;

(19) effectiveness of staff utilization and training;

(20) completeness of client records;

(21) review of the management of care of individual clients or targeted types of clients or cases for the appropriateness of the clinical judgment of the practitioner(s) in obtaining consultation and managing the case relative to standards of care and policies; and make recommendations for any improvements of care; and

(22) review and analyze outcome data and trends, and client satisfaction survey results.

[7.10.2.26 NMAC - N, 3/1/2016]

7.10.2.27 MINIMUM STAFFING REQUIREMENTS: Qualified and properly licensed professional and clinical staff shall provide quality family centered maternal and newborn care consistent with the scope of practice authorized under each individual practitioner's license(s). Direct care staff shall have access to consulting clinical specialists and support by administrative and ancillary personnel consistent with the volume of clients enrolled for care and the scope of services offered. The facility shall maintain adequate numbers of professional and support staff on duty, present on premises, and on-call to meet routine service demands, as well as high service demands and emergencies in order to assure client safety, satisfaction, and that no mother in active labor is unattended. The facility shall have on staff at a minimum:

A. a midwife or physician on duty whenever there is a client in the facility in active labor or immediately postpartum;

B. a midwife or physician on immediate call whenever clients are in the facility receiving clinical services;

C. personnel trained in the use of emergency equipment and in BLS and NRP must be on duty whenever a client is within the freestanding birth center receiving clinical services; this includes nighttime hours when clients are within the freestanding birth center in labor or postpartum;

D. an on-site administrator managing the daily operations and implementing the policies and procedures;

E. a clinical director responsible for implementing facility clinical policies;

F. an internal quality committee that ensures the effectiveness of the quality assurance and performance improvement process at the facility; and

G. an external quality committee that provides in-depth peer review.

[7.10.2.27 NMAC - N, 3/1/2016]

7.10.2.28 MINIMUM STAFF QUALIFICATIONS: The facility staff minimum qualifications shall be:

A. Administrator qualifications: The administrator must:

(1) be at least age 21;

(2) have a high school diploma or general educational development (GED) certificate and two years of administrative or management experience;

(3) be a licensed healthcare professional; and

(4) if not a licensed healthcare professional, be a forty percent or greater owner in the facility with relevant business experience.

B. Clinical director qualifications: The clinical director shall be at least 21 years of age and must have the following qualifications:

(1) must be professionally licensed in a health care field;

(2) must have two years of birthing and labor experience; and

(3) must have two years of experience performing risk assessments to determine low risk pregnancy eligibility.

C. Other clinical staff qualifications: All other clinical staff must have the following qualifications:

(1) must be at least 18 years of age;

(2) must be licensed, certified or trained appropriately for the care provided; prior to providing direct client care, the clinical director shall

verify qualifications and competence;

(3) must comply with any and all caregiver criminal history screening requirements and not be currently shown on any federal or state caregiver disqualification lists or certified nursing assistant (CNA) disqualification lists or the employee abuse registry.

D. Staff at birth: In addition to any and all other requirements for licensed professionals, each birth shall be attended by two persons currently trained in:

(1) adult cardiopulmonary resuscitation equivalent to American heart association class C BLS; and

(2) neonatal resuscitation endorsed by American academy of pediatrics/American heart association.

E. Direct service staff: Each staff member who provides direct medical services to clients, such as physicians, midwives, nurses, nurse practitioners and physician's assistants, who are required to be licensed, registered or certified by the state of New Mexico, must have a current license, registration or certificate from the state of New Mexico at the time they provide the services.
[7.10.2.28 NMAC - N, 3/1/2016]

7.10.2.29 STAFF RECORDS: At a minimum, staff records shall include:

A. Personnel records: Each facility licensed pursuant to these regulations must maintain complete written records for each staff member, employee, contractor and volunteer working at the facility, that are available for review upon request by the licensing authority. At a minimum, each person's records must contain the following:

(1) personal identification and demographic information;

(2) all qualifications;

(3) all current license(s) and training certification(s), including inoculations, if applicable;

(4) annual performance evaluations;

(5) documentation that the employee has read and received the personnel policies;

(6) documentation of required occupational safety and health administration (OSHA) and Health Insurance Portability and Accountability Act (HIPAA) training; and

(7) copy of caregiver criminal history screening clearance letter for all applicable caregivers including any volunteers acting as caregivers and documentation that the employee abuse registry has been reviewed to verify the staff person or caregiver is not a risk to client or newborn health, safety and welfare.

B. Staff scheduling records: The facility must:

(1) keep weekly or monthly schedules covering all services;

(2) document in each client record all staff present at labor, birth and postpartum through discharge; and

(3) keep all schedules on file for a minimum of six months.

C. Staff evaluation and development: The facility must have written documented policies and procedures for staff orientation, on-going staff development, staff supervision and staff evaluation, which include but are not limited to the following:

(1) client and facility emergency and safety procedures;

(2) quality assurance and performance improvement programs; and

(3) documentation of staff compliance with current licensure, certification, training and position requirements, including initial and annual training requirements.
[7.10.2.29 NMAC - N, 3/1/2016]

7.10.2.30 RESEARCH:

A. If a facility is conducting research activities, the facility must have written policies and procedures for conducting the research being done, documentation that the study has received institutional review board (IRB) approval and a consent form for each client involved in the research in the client's record.

B. When research is conducted by the facility or by the employees or by affiliates of the freestanding birth center or when the facility is used as a research site, such that the facility's clients and staff are involved in or the subjects of research; the research must be conducted by qualified researchers, having evidence in formal training and experience in the conduct of clinical, epidemiologic or sociologic research, in accordance with the written, approved research policies and procedures, by staff trained to conduct such research and in a manner that protects the client's health, safety and right to privacy and the facility and its clients from unsafe practices.
[7.10.2.30 NMAC - N, 3/1/2016]

7.10.2.31 PHARMACEUTICAL SERVICES:

A. One individual shall be designated responsibility for pharmaceutical services to include accountability and safeguarding.

B. Keys to the drug room or pharmacy must only be made available to authorized personnel by the individual having responsibility for pharmaceutical services.

C. Drugs and biologicals must be stored, prepared and administered in accordance with acceptable standards of practice, in compliance with all New Mexico state board of pharmacy requirements and in compliance with any and all other applicable federal and state statutes and regulations.

D. Outdated drugs and biologicals must be disposed of in accordance with methods required by the New Mexico state board of pharmacy.

E. Adverse reactions and allergies to medications must be reported to the licensed provider responsible for the client and must be documented in the client's record.

F. Blood products are limited to those used to prevent isoimmunization during and after pregnancy and shall only be administered by a properly licensed personnel acting within the scope of their license.

G. Medication administration shall only be performed by a licensed provider acting within the scope of their license.

H. Blood, including whole blood, packed red cells, plasma, cryoprecipitate, or other blood factors may not be administered in a freestanding birth center facility.
[7.10.2.31 NMAC - N, 3/1/2016]

7.10.2.32 LABORATORY SERVICES:

A. A facility that provides on-site laboratory services shall meet all current CLIA regulations and must have a CLIA certificate appropriate to the level of testing (e.g., certificate of waiver, provider performed microscopy (PPM) or certification for moderately complex testing or waiver).

B. A facility that contracts out its laboratory services shall only contract with a laboratory that meets all current CLIA regulations and has CLIA

certificates appropriate for all testing requested by the facility.

C. All lab test results performed either at the facility, or by contract, or by other arrangement must be entered into the client record(s).

D. All laboratory procedures shall be conducted in accordance with acceptable standards of practice.

E. Facilities that provide laboratory services or collect specimens for testing by outside CLIA laboratories must provide the following:

(1) laboratory work counter(s) with a sink and electrical outlets;

(2) lavatory or counter sink(s) equipped for hand washing, or alcohol-based hand sanitizer to decontaminate hands;

(3) adequate storage for lab supplies;

(4) specimen collection facilities with a toilet and lavatory;

(5) blood collection facilities shall have seating space, a work counter and hand washing facilities;

(6) appropriate storage facilities to ensure specimens are maintained at correct temperatures and to prevent any deterioration or contamination.

[7.10.2.32 NMAC - N, 3/1/2016]

7.10.2.33 INFECTION CONTROL:

A. The facility shall develop, implement and enforce written infection control policies and procedures to minimize the transmission of infection. Policies shall include educational course requirements; decontamination, disinfection, sterilization, and storage of sterile supplies; and cleaning and laundry requirements.

B. The facility shall provide sterilization equipment adequate to meet the requirements for sterilization of critical items. Equipment shall be maintained in accordance with the manufacturers' specifications, and operated to perform with accuracy, the sterilization of critical items. Live spore testing for the effectiveness of sterilization will be performed as defined by facility policy. Devices such as steri-gauges or sterilization tape will not be sufficient to assess the effectiveness of the sterilizers. The facility shall have a methodology to permit the backtracking of equipment use in case a sterilizer or any other medical equipment fails.

C. Where cleaning, preparation and sterilization functions are performed in the same room or unit, soiled or contaminated supplies and equipment shall be physically separated from the clean or sterilized supplies and equipment.

D. Each facility shall have policies and procedures for the handling, processing, storing and transporting of clean and dirty laundry.

E. All special waste including blood, body fluids, placentas, sharps and biological indicators, shall be disposed of in accordance with OSHA and the New Mexico environment department standards for bio hazardous waste.

F. Each facility shall have written policies and procedures on terminal cleaning of birthing rooms to ensure infection control and client safety.

[7.10.2.33 NMAC - N, 3/1/2016]

7.10.2.34 EMERGENCY MEDICAL SERVICES: All freestanding birth centers shall have a written policy regarding emergency transfer for clients or newborns including emergency response personnel and accepting hospital facility which shall be followed in the event of an emergency.

A. Each facility must maintain and have easily accessible an emergency response cart(s) or emergency response tray(s) to provide emergency lifesaving procedures for an adult and newborn and comply with the following:

(1) emergency response carts or trays shall be supplied with the drugs and biologicals commonly used in life saving procedures, along with supplies and equipment determined by the clinical director of the facility;

(2) each emergency response cart or tray shall have lists of equipment and supplies to be maintained and ready and for use as an inventory guide;

(3) emergency response carts or trays must be replenished as supplies or equipment are used;

(4) emergency response carts or trays shall be checked on a monthly basis for completeness and a log maintained with date and by whom the check was made; and

(5) all clinical staff must know the location of and be trained in the use of the emergency response.

B. Provisions for emergency calls:

(1) an easily accessible hard wired telephone for summoning help, in case of emergency, must be available in the facility and in the birthing room during a labor; and

(2) a list of emergency numbers including, but not limited to,, fire department, police department, ambulance services, local hospital and poison control center must be prominently posted by the telephone(s).

[7.10.2.34 NMAC - N, 3/1/2016]

7.10.2.35 BUSINESS HOURS AND OPERATIONAL RECORDS: The facility shall post its hours of operation in a public location that can be seen by clients and visitors both inside and outside the facility. The facility shall keep all operational reports and records on file at the facility and make them available for review to document compliance with these regulations upon request of the licensing authority. Business and operational records shall include, but are not limited to:

A. names and addresses of all license owners, controlling parties, management company, if applicable, administrator, clinical director and all of the members of the internal and external quality committees;

B. a copy of the most recent version of the licensing regulations;

C. any and all agreements and contracts with other health care providers to provide services;

D. the most recent life safety and health surveys conducted by the licensing authority and any variances or waivers granted;

E. the most recent fire inspection report by the fire authority having jurisdiction;

F. a log of fire and emergency evacuation drills conducted by the freestanding birth center;

G. a valid and current state board of pharmacy drug permit;

H. the most recent state board of pharmacy inspection of the drug room;

I. the most recent CLIA certificate applicable for the type of specimens tested or waiver(s) for any specimen testing;

J. a log tracking infection control and sterilization processes demonstrating compliance with these regulations and all other applicable statutes and regulations;

K. if applicable, New Mexico environment department approval of private water system;

L. if applicable, New Mexico environment department approval of private waste and sewage disposal.
[7.10.2.35 NMAC - N, 3/1/2016]

7.10.2.36 BUILDING STANDARDS FOR FREESTANDING BIRTH CENTERS: The purpose of a freestanding birth centers is to establish a safe, homelike environment for healthy women anticipating a low risk birth so long as there is sufficient space, furnishings, equipment and supplies to comfortably accommodate the number of families, mothers, newborns and infants served by the facility and the staff necessary for providing the services.

A. The facilities may be in a house or residential structure adapted or renovated for birth center use, if allowed and approved by the local zoning authority.

B. If the facility is based in an office building, consultation and examining rooms must be separate from the dedicated birth room(s).

C. Freestanding birth centers must comply with life safety code requirements in accordance with the applicable national fire protection association (NFPA) 101 life safety code edition. Birth centers may be classified as business occupancies if their capacity is restricted to occupancy by fewer than four active births at any one time and the physical layout shall not render clients, not including infants, incapable of self-preservation.

D. All freestanding birth center facilities licensed under these regulations must be accessible to and useable by handicapped clients, employees, staff and visitors.
[7.10.2.36 NMAC - N, 3/1/2016]

7.10.2.37 MINIMUM FACILITY SPACE REQUIREMENTS: Each facility shall include and provide sufficient space for the following areas:

A. Public areas: The facility shall provide in the public areas:

(1) sufficient parking space(s) for the public, each birthing room and each employee present on any single shift;

(2) a reception and information counter or desk;

(3) a waiting area for visitors;

(4) convenient and accessible wheelchair storage;

(5) convenient and accessible drinking fountain or bottled water.

B. Administrative and work areas: The facility shall provide administration and work areas including:

(1) general or individual office(s) for business transactions, records, administrative and professional staff;

(2) storage for staff personal effects which can be locked in drawers or cabinets.

C. Toilets, lavatories and bathing facilities: All fixtures and plumbing in the facility shall be installed in compliance with applicable state and local building codes and shall include:

(1) a toilet and sink in each birth room, and a tub or shower available for use by the laboring mother within the facility;

(2) a separate toilet and sink for staff use;

(3) at least one public and visitor restroom conveniently located and accessible to the handicapped which includes a toilet and sink;

(4) a hand washing sink in all toilet rooms which shall be kept supplied with single use or individual use towels for hand drying or provided with mechanical blower;

(5) automatic hand sanitizer units may be used instead of a sink.

D. Nourishment station: A facility nourishment center shall be provided and include the following:

(1) work counter;

(2) sink;

(3) refrigerator;

(4) storage cabinets; and

(5) equipment for hot and cold nourishment; the nourishment area may be available for staff use, and may within space limited facilities also function as the staff lounge.

E. Examination rooms: If prenatal or other health care is provided at the facility, exam rooms shall be separated from the dedicated birth room(s) and shall have:

(1) sufficient size to accommodate the necessary equipment and personnel consistent with the purpose of the room;

(2) all walls in an exam room shall be a minimum of eight feet long; and

(3) a hand washing sink shall be located in each exam room or immediately adjacent to the exam room.

F. Birth rooms: The facility shall have one birth room available for each client in active labor which is and includes:

(1) sufficient size to accommodate necessary equipment and personnel consistent with the purpose of the room;

(2) all walls constructed to a minimum length of 10 feet long;

(3) birth rooms and bathrooms located to provide for complete privacy during use;

(4) clear floor space to permit unimpeded egress and access for emergency transportation equipment;

(5) located to provide unimpeded rapid access to a facility exit which accommodates emergency transportation vehicles and equipment; and

(6) furniture arrangement in the birth room that permits a minimum clear dimension of 36 inches on at least one side for the full length of the bed where birthing can occur.

G. Equipment and supplies:

(1) Equipment: The facility shall be equipped with all necessary items and equipment needed to provide low-risk maternity delivery and care, as well as all equipment available and ready to provide emergency medical services, including emergency carts or emergency trays, in life threatening events to mother and baby including, but not limited to,:

(a) cardiopulmonary resuscitation (CPR) equipment, oxygen, positive pressure mask, suction, intravenous (IV) equipment, equipment for maintaining infant temperature and ventilation, blood expanders, and medications identified in professional staff protocols to meet emergency needs of mother and baby at the facility and during transport to an acute care setting;

(b) equipment for performing standard screening, laboratory tests, and for sterilizing instruments and other materials, including programs for regular inspection and training in the use of resuscitation and other equipment as outlined in the policies and procedures manual which shall be available on site at all times; and

(c) maintenance of all equipment in accordance with manufacturer's specifications.

(2) Supplies: The facility's supply inventory shall be sufficient to care for the number of childbearing women and families registered for care at any one time.

H. Housekeeping and support areas: The facility shall provide housekeeping and support areas, including:

(1) general storage facilities for supplies and equipment;

(2) drug storage and administration areas which comply with New Mexico board of pharmacy regulations;

(3) clean storage consisting of a separate room, space or closet for storing clean and sterile supplies;

(4) soiled holding with separate collection, storage and disposal for all soiled materials used and stored at the facility.

I. Laundry services: The facility shall provide laundry services for both facility use and client care, on the premises or through laundry and linen services:

(1) on-site laundry facilities shall be provided with necessary washing and drying equipment;

(2) soiled laundry shall be kept in a separate storage area from the clean laundry storage area;

(3) soiled laundry shall not be stored in the nourishment, kitchen or dining areas;

(4) in facilities with four or more birthing rooms, washers shall be located in separate rooms from the dryers and shall have negative air pressure from the other rooms in the facility.

[7.10.2.37 NMAC - N, 3/1/2016]

7.10.2.38 MINIMUM SAFETY REQUIREMENTS: Each facility shall comply with the following minimum safety requirements:

A. Exits:

(1) Each facility and each floor of the facility shall have exits as required and permitted by current fire protection and life safety codes adopted by the state.

(2) Exit ways must be kept free from obstructions at all times.

(3) All exit and exit access doors must be at least 36 inches wide and accommodate wheelchairs.

B. Corridors:

(1) Minimum corridor width shall be three feet where the occupancy load is less than 50, or three feet eight inches, if the occupant load is greater than 50.

(2) Narrower corridor widths may be allowed in staff areas not in the exit pathway if not in conflict with applicable building or fire codes and approved by the licensing authority prior to occupying the facility.

C. Doors and windows:

(1) All doors in spaces occupied or used by clients shall be solid core and have a minimum width of 32 inches wide and be a minimum of one and three-quarter inches thick.

(2) Each birthing room must have an operable window or alternate means to provide adequate ventilation and emergency egress.

D. Emergency lighting: The facility shall provide emergency lighting which:

(1) activates automatically upon any disruption of electrical service;

(2) is sufficient to illuminate paths of egress and exits in the facility; and

(3) for facilities with four or more birth rooms, is located in each birth room.

[7.10.2.38 NMAC - N, 3/1/2016]

7.10.2.39 MINIMUM ENVIRONMENTAL REQUIREMENTS: Each facility shall comply with the following minimum environmental requirements:

A. Floors and walls: All finishes shall be kept clean and shall be of the type that is appropriate for the cleaning methods and solutions used to maintain a clean and safe environment.

(1) Floor material shall be readily cleanable and wear resistant.

(2) In all areas subject to wet cleaning, floor materials shall not be physically affected by liquid germicidal or cleaning solution.

(3) Floors subject to traffic while wet including showers and bath areas shall have a slip resistant surface.

(4) Wall finishes shall be washable and in the proximity of plumbing fixtures, shall be smooth and moisture resistant.

(5) In areas subject to wet cleaning, the intersection of the floor and wall shall be sealed with a coved base or a wood bases tightly sealed connection without voids.

(6) Floor and wall areas penetrated by pipes, ducts and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

(7) Threshold and expansion joint covers shall be flush with the floor surface to facilitate use of wheelchairs and carts.

B. Water: The facility shall provide water in sufficient quantity to support all services provided and shall:

(1) insure that if the water is obtained from a private water system and not a publically approved system, the water supply is inspected, tested and approved by the New Mexico environment department or appropriate authority prior to licensure; the facility shall be responsible for insuring that subsequent periodic testing and inspection of any private water systems is made at intervals prescribed by the New Mexico environment department or the legally responsible authority which oversees or inspects, tests, and approves the specific system;

(2) provide hot water at each hot water outlet at all times with hot water for hand washing facilities, tubs and showers not exceeding 120 degrees Fahrenheit at the delivery point.

C. Water heaters:

(1) Must be able to supply hot water to all hot water taps within the facility at full pressure during peak demand periods and maintain a maximum temperature of 120 degrees Fahrenheit.

(2) Must be enclosed and separated from other parts of the building premises by construction as required by applicable state and local building codes, if using fired fuel.

(3) Must be equipped with an operable pressure relief valve (pop-off-valve) which is tested on a schedule recommended by the manufacturer.

D. Sewage and waste disposal: The facility shall provide for proper sewage and waste disposal at all times including:

(1) If the facility sewage and liquid waste system is not part of an approved public system, the private sewage system must be inspected, tested and approved by the New Mexico environment department prior to licensure. The facility shall be responsible to insure that periodic testing or inspection of

its private sewage disposal systems is made as required by the New Mexico environment department or the legally responsible authority which oversee or inspects the specific system.

(2) If municipal or community garbage collection and disposal services are not available, the method of collection and disposal of the facility's solid waste must be inspected and approved by the New Mexico environment department or the legally responsible authority which oversee or inspects the specific system.

(3) All external garbage and refuse receptacles must be kept clean, durable, have tight fitting lids, must be insect, rodent and animal proof, washable, leak proof, and constructed of materials which will not absorb liquids.

E. Environmental services: The facility shall provide:

(1) A separate lockable storage area or closet for environmental cleaning supplies.

(2) Proper disposal of all liquids and waste resulting from cleaning contaminated areas.

(3) Proper procedures shall be maintained, and techniques used, consistent with the facility's policies and procedures and applicable regulations for disposal of bio-waste and sanitary disposal of all other wastes.

F. Cleaning:

(1) The facility must be kept clean and free from offensive odors and accumulations of dirt, rubbish, dust, and safety hazards.

(2) Deodorizers must not be used to mask odors caused by unsanitary conditions or poor housekeeping practices.

(3) Safe and effective procedures for cleaning and sanitizing all facility areas and equipment shall be followed consistently to safeguard the health of the clients, staff, and visitors.

[7.10.2.39 NMAC - N, 3/1/2016]

7.10.2.40 MINIMUM LIGHTING AND ELECTRICAL STANDARDS:

A. Electrical standards: The facility shall provide that:

(1) all facility electrical sources, supplies, and equipment comply with all applicable national, state and local electrical codes;

(2) all circuit breakers or fused switches provide electrical disconnection and over current protection and are:

(a) readily accessible for use and maintenance;

(b) set apart from traffic lanes; and

(c) located in a dry, ventilated space.

(3) all panel boards servicing lighting and appliance circuits shall be on the same floor and in the same facility area as the circuits they serve; and

(4) each panel board shall be marked showing the service area of each circuit breaker or fused switch.

B. Lighting: The facility shall insure that:

(1) all spaces occupied by people, machinery or equipment within buildings, at outside building approaches and at parking areas have adequate lighting to prevent injury;

(2) lighting shall be sufficient to make all parts of an area clearly visible;

(3) lighting fixtures shall be shielded as required by code;

(4) lighting fixtures shall be selected and located for the comfort and convenience of the clients, staff and public; and

(5) a fixed or portable examination light shall be provided for all examination and birth rooms.

C. Electrical cords and electrical receptacles: Power strips may not be used as a substitute for adequate electrical outlets in a facility. Power strips may be used for a computer, monitor and printer. Power strips shall not be used with medical devices. The facility shall take precautions if power strips are used, including: installing internal ground fault and over-current protection devices, preventing cords from becoming tripping hazards, and using power strips that are adequate for the number and types of devices used. The facility shall take all necessary precautions to insure power overloads and excessive power demands on any circuit do not cause overheating or fire. Ground fault circuit interrupter (GFCI) shall be installed in locations near water sources to prevent electrocution of persons.

(1) All electrical cords and extension cords must be:

(a) U/L approved;

(b) replaced as soon as they show wear;

(c) not used under any circumstances as a general wiring method;

(d) plugged into an electrical receptacle within the room where used and not be connected in one room and extended to anything outside the room; and

(e) not be used in series.

(2) Electrical receptacles must be:

(a) installed as required by applicable codes;

(b) appropriately rated for each use and function; and

(c) any use of wall mounted outlets to expand the receptacle capacity or to be used as a surge protector and connected to any medical equipment is prohibited.

[7.10.2.40 NMAC - N, 3/1/2016]

7.10.2.41 MINIMUM HEATING, VENTILATION AND AIR CONDITIONING STANDARDS: The facility shall provide and maintain heating, ventilating and air conditioning or air cooling systems sufficient to keep all facility occupants comfortable which include but are not limited to:

A. Heating, air-conditioning or air cooling, piping, boilers and ventilation equipment furnished, installed and maintained to meet all requirements of applicable state and local mechanical, electrical and construction codes.

B. Use of a heating method that consistently provides a minimum indoor winter design capacity of 75 degrees fahrenheit with accessible temperature adjustment controls appropriate for all occupants' comfort.

C. A prohibition against the use of unvented heaters, open flame heaters or portable heaters.

D. An ample supply of outside air shall be provided in all spaces where fuel fired boilers, furnaces or heaters are located to assure proper combustion.

E. All fuel fired boilers, furnaces or heaters shall be connected to an approved venting system which takes all combustion products directly to the outside air.

F. Adequate ventilation at all times to provide fresh air and the control of unpleasant odors inside the facility.

G. A one hundred percent

automatic cutoff control valve in event of pilot failure for all gas-fired heating equipment.

H. A system for maintaining all occupants' comfort during periods of hot weather.

I. Protection of all boiler, furnace or heater rooms from other parts of the building by construction having a fire resistance rating of not less than one hour with doors that open to the interior being self-closing with a three-quarter hour fire resistance rating.

J. Filters having efficiencies as required by state codes for all central ventilation and air conditioning systems.

[7.10.2.41 NMAC - N, 3/1/2016]

7.10.2.42 FIRE SAFETY: All current applicable requirements of state and local codes for fire prevention and safety must be met by the facility including, but not limited to:

A. Fire clearance and inspections: Each facility must request from the fire authority having jurisdiction an annual fire inspection. If the policy of the fire authority having jurisdiction does not provide for annual inspection of the freestanding birth center, the facility must document the date the request was made and to whom. If the fire authorities make annual inspections, a copy of the latest inspection must be kept on file in the facility.

B. Staff fire safety training:

(1) All facility staff must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility shall request the fire authority having jurisdiction to give periodic instruction in fire prevention and techniques of evacuation.

(2) Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, faulty equipment, blocked exits or exit ways and any other condition which could cause burns, fall, or other personal injury.

(3) Fire and evacuation drills: The facility must conduct at a minimum on a quarterly basis at least one fire drill and evacuation drill. A log must be maintained by the facility showing the date, time, number of staff participating and outlining any problems noted in the conduct of the drill.

C. Evacuation plan and preparedness plans: Each facility must have a fire and disaster evacuation plan conspicuously posted in each separate area of the building showing routes of evacuation in case of fire or disaster or other emergency, as well as a disaster preparedness plan in the event of man-made or natural disaster.

D. Provisions for emergency calls: An easily accessible hard wired telephone for summoning help, in case of emergency, must be available in the facility and a list of emergency numbers, including, but not limited to, fire department, police department, ambulance services and poison control center must be prominently posted by the telephone(s).

E. Fire extinguishers:

(1) fire extinguishers as approved by the state fire marshal or fire prevention authority having jurisdiction must be located in the freestanding birth center;

(2) fire extinguishers must be properly maintained as recommended by the manufacturer, state fire marshal or fire authority having jurisdiction; and

(3) all fire extinguishers must be inspected yearly and recharged as specified by the manufacturer, state fire marshal or fire authority having jurisdiction; all fire extinguishers must be tagged, noting the date of inspection.

F. Alarm system: A manually operated, electrically supervised fire alarm system shall be installed in each facility as required by applicable national fire protection association (life safety code) 101 (NFPA 101). Facilities located in multi-story buildings must have a fire alarm system as required by NFPA 101.

G. Fire detection system: The facility must be equipped with smoke detectors as required by the NFPA 101 (life safety code) and approved as to number, type and placement in writing by the fire authority having jurisdiction.

[7.10.2.42 NMAC - N, 3/1/2016]

7.10.2.43 INCORPORATED AND RELATED STATUTES, RULES AND CODES: The facilities that are subject to this rule are also subject to other statutes, rules, codes and standards that may, from time to time, be amended, including all authorizing statutes under which any applicable regulations have been promulgated. Applicable regulations include, but are not limited to the following:

A. Health Facility Licensure Fees and Procedures, New Mexico department of health, 7.1.7 NMAC.

B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico department of health, 7.1.8 NMAC.

C. Adjudicatory Hearings for Licensed Facilities, New Mexico department of health, 7.1.2 NMAC.

D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC.

E. Employee Abuse Registry, 7.1.12 NMAC.

F. Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC.

[7.10.2.43 NMAC - N, 3/1/2016]

7.10.2.44 SEVERABILITY: If any section or provision or application of these regulations is held to be invalid, the remainder and its application to other situations or persons shall not be affected or interfere with the remaining requirements provided by these regulations.

[7.10.2.44 NMAC - N, 3/1/2016]

HISTORY OF 7.10.2 NMAC: [RESERVED]

HEALTH, DEPARTMENT OF

This is an amendment to 7.34.2 NMAC, Section 7, effective 2/29/2016.

7.34.2.7 DEFINITIONS:

A. "Act" means the Lynn and Erin Compassionate Use Act, NMSA 1978, Sections 26-2B-1 through 26-2B-7.

B. "Adequate supply" means an amount of cannabis, derived solely from an intrastate source and in a form approved by the department, that is possessed by a qualified patient or collectively possessed by a qualified patient and the qualified patient's primary caregiver, that is determined by the department to be no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months or 90 consecutive calendar days.

C. "Administrative review committee" means an intra-department committee that reviews qualified patient or primary caregiver application denials, licensed producer denials made by the program manager, or the [~~imposition of a~~] summary suspension

of a producer's license, in accordance with department rules. The administrative review committee shall consist of the chief medical officer of the department (or that's person's designee); a deputy secretary of the department (or that person's designee), and the chief nursing officer of the department (or that person's designee).

D. "Administrative withdrawal" means the procedure for the voluntary withdrawal of a qualified patient or primary caregiver from the medical cannabis program.

E. "Advisory board" means the medical cannabis advisory board consisting of eight practitioners representing the fields of neurology, pain management, medical oncology, psychiatry, infectious disease, family medicine, and gynecology.

F. "Applicant" means any person applying for enrollment or re-enrollment in the medical cannabis program as a qualified patient, primary caregiver, or licensed producer.

G. "Approved laboratory" means a laboratory that has been approved by the department specifically for the testing of cannabis, concentrates, and cannabis derived products.

H. "Batch" means, with regard to usable cannabis, a homogenous, identified quantity of cannabis no greater than five pounds that is harvested during a specified time period from a specified cultivation area, and with regard to concentrated and cannabis-derived product, means an identified quantity that is uniform, that is intended to meet specifications for identity, strength, and composition, and that is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling protocol.

I. "Cannabidiol ("CBD")" is a cannabinoid and the primary non-psychoactive ingredient found in cannabis.

J. "Cannabis" means all parts of the plant, cannabis sativa, and cannabis indica, whether growing or not and the resin extracted from any part of the plant.

K. "Cannabis-derived product" means a product, other than cannabis itself, which contains or is derived from cannabis, not including hemp.

L. "Concentrated cannabis-derived product ("concentrate")" means a cannabis-derived product that is manufactured by a mechanical or chemical process that separates any cannabinoid from the cannabis plant, and that contains (or that is intended to contain at the time of sale or distribution) no less than thirty-percent (30%) THC by weight.

M. "Courier" means a person or entity that transports usable cannabis within the state of New Mexico from a licensed non-profit producer to a qualified patient or primary caregiver, to another non-profit producer, to an approved laboratory, or to an approved manufacturer.

N. "Debilitating medical condition" means:

(1) cancer;

(2) glaucoma;

(3) multiple sclerosis;

(4) damage to the nervous tissue of the spinal cord, with objective neurological indication of intractable spasticity;

(5) epilepsy;

(6) positive status for human immunodeficiency virus or acquired immune deficiency syndrome;

(7) admission into hospice care in accordance with rules promulgated by the department; or

(8) any other medical condition, medical treatment, or disease as approved by the department which results in pain, suffering, or debility for which there is credible evidence that medical use cannabis could be of benefit.

O. "Department" means the department of health or its agent.

P. "Facility" means any building, space, or grounds licensed for the production, possession, testing, manufacturing, or distribution of cannabis, concentrates, or cannabis-derived products.

Q. "Intrastate" means existing or occurring within the state boundaries of New Mexico.

R. "Laboratory applicant" means a laboratory that seeks to become an approved laboratory, or that seeks renewal of approval as an approved laboratory, in accordance with this rule.

S. "License" means the document issued by the department granting the legal right to produce medical cannabis for a specified period of time.

T. "Licensed producer" means a person or entity licensed to produce medical cannabis.

U. "Licensure" means the process by which the department grants permission to an applicant to produce cannabis.

V. "Lot" means an identified portion of a batch, that is uniform and that is intended to meet specifications for identity, strength, and composition; or, in the case of a cannabis-derived product or concentrate, an identified quantity produced in a specified period of time in a manner that is uniform and that is intended to meet specifications for identity, strength, and composition.

W. "Male plant" means a male cannabis plant.

X. "Manufacture" means to make or otherwise produce cannabis-derived product or concentrate.

Y. "Manufacturer" means a business entity that manufactures cannabis-derived product that has been approved for this purpose by the medical cannabis program.

Z. "Mature female plant" means a harvestable female cannabis plant that is flowering.

AA. "Medical cannabis program" means the administrative body of the department charged with the management of the medical cannabis program and enforcement of program regulations, to include issuance of registry identification cards, licensing of producers, and regulation of manufacturing and distribution.

BB. "Medical cannabis program manager" means the administrator of the medical cannabis program who holds that title.

CC. "Medical director" means a medical practitioner designated by the department to determine whether the medical condition of an applicant qualifies as a debilitating medical condition eligible for enrollment in the program, and to perform other duties.

DD. "Medical provider certification for patient eligibility form" means a written certification form provided by the medical cannabis program signed by a patient's practitioner that, in the practitioner's professional opinion, the patient has a debilitating medical condition as defined by the act or this part and would be anticipated to benefit from the use of cannabis.

EE. "Minor" means an individual less than 18 years of age.

FF. "Paraphernalia" means any equipment, product, or material of any kind that is primarily intended or designed for use in compounding, converting, processing, preparing, inhaling, or otherwise introducing cannabis or its derivatives into the human body.

GG. "Patient enrollment/ re-enrollment form" means the registry identification card application form for patient applicants provided by the medical cannabis program.

HH. "Personal production license" means a license issued to a qualified patient participating in the medical cannabis program, to permit the qualified patient to produce medical cannabis for the qualified patient's personal use, consistent with the requirements of department rule.

II. "Petitioner" means any New Mexico resident or association of New Mexico residents petitioning the advisory board for the inclusion of a new medical condition, medical treatment, or disease to be added to the list of debilitating medical conditions that qualify for the use of cannabis.

JJ. "Plant" means any cannabis plant, cutting, or clone that has roots or that is cultivated with the intention of growing roots.

KK. "Policy" means a written statement of principles that guides and determines present and future decisions and actions of the licensed producer.

LL. "Practitioner" means a person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act, Sections 30-31-1 *et seq.*, NMSA 1978.

MM. "Primary caregiver" means a resident of New Mexico who is at least 18 years of age and who has been designated by the qualified patient or their representative and the patient's practitioner as being necessary to take responsibility for managing the well-being of a qualified patient with respect to the medical use of cannabis pursuant to the provisions of the Lynn and Erin Compassionate Use Act, Section 26-2B-1 *et seq*., NMSA 1978.

NN. "Primary caregiver application form" means the registry identification card application form provided by the medical cannabis program.

OO. "Private entity" means a private, non-profit organization that applies to become or is licensed as a producer and distributor of cannabis, concentrates, or cannabis-derived products.

PP. "Proficiency testing" means testing conducted by the department or its agent to determine the ability of a laboratory applicant or approved laboratory to accurately identify presence, quantity, or other factors pertaining to a given analyte.

QQ. "Qualified patient" means a resident of New Mexico who has been diagnosed by a practitioner as having a debilitating medical condition and has received a registry identification card issued pursuant to the requirements of the act or department rules.

RR. "Registry identification card" means a document issued and owned by the department which identifies a qualified patient authorized to engage in the use of cannabis for a debilitating medical condition or a document issued by the department which identifies a primary caregiver authorized to engage in the intrastate possession and administration of cannabis for the sole use of the qualified patient.

SS. "Representative" means an individual designated as the applicant's or petitioner's agent, guardian, surrogate, or other legally appointed or authorized health care decision maker.

TT. "Secretary" means the secretary of the New Mexico department of health.

UU. "Secure grounds" means a facility that provides a safe environment to avoid loss or theft.

VV. "Security alarm system" means any device or series of devices capable of alerting law enforcement , including, but not limited to, a signal system interconnected with a radio frequency method such as cellular, private radio signals, or other mechanical or electronic device used to detect or report an emergency or unauthorized intrusion.

WW. "Security policy" means the instruction manual or pamphlet adopted or developed by the licensed producer containing security policies, safety and security procedures, and personal safety and crime prevention techniques.

XX. "Seedling" means a cannabis plant that has no flowers.

YY. "Segregate" means to separate and withhold from use or sale batches, lots, cannabis, usable cannabis, or cannabis-derived products in order to first determine its suitability for use through testing by an approved laboratory.

ZZ. "THC" means tetrahydrocannabinol, a cannabinoid that is the primary psychoactive ingredient in cannabis.

AAA. "Technical evidence" means scientific, clinical, medical, or other specialized testimony, or evidence, but does not include legal argument, general comments, or statements of policy or position concerning matters at issue in the hearing.

BBB. "Testing" means the process and procedures provided by an approved laboratory for testing of cannabis and cannabis derived products, consistent with provisions of this rule.

CCC. "Unit" means a quantity of usable cannabis, concentrate, or cannabis-derived product that is used in identifying the maximum supply that a qualified patient may possess for purposes of department rules.

DDD. "Usable cannabis" means the dried leaves and flowers of the female cannabis plant and cannabis-derived products, including concentrates, but does not include the seeds, stalks, or roots of the plant.

[7.34.2.7 NMAC - Rp, 7.34.2.7 NMAC, 2/27/2015; A, 2/29/2016]

HEALTH, DEPARTMENT OF

This is an amendment to 7.34.3 NMAC, Sections 7, 8 and 16, effective 2/29/2016.

7.34.3.7 DEFINITIONS:

A. "Act" means the Lynn and Erin Compassionate Use Act, Sections 26-2B-1 through 26-2B-7 NMSA 1978.

B. "Adequate supply" means an amount of cannabis, derived solely from an intrastate source and in a form approved by the department, that is possessed by a qualified patient or collectively possessed by a qualified patient and the qualified patient's primary caregiver, that is determined by the department to be no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months or 90 consecutive calendar days.

C. "Administrative review committee" means an intra-department committee that reviews qualified patient or primary caregiver application denials, licensed producer denials made by the program manager, or the [~~imposition of a~~] summary suspension of a producer's license, in accordance with department rules. The administrative review committee shall consist of the chief medical officer of the department (or that's person's designee); a deputy secretary of the department (or that person's designee), and the chief nursing officer of the department (or that person's designee).

D. "Administrative

withdrawal" means the procedure for the voluntary withdrawal of a qualified patient or primary caregiver from the medical cannabis program.

E. "Advisory board" means the medical cannabis advisory board consisting of eight practitioners representing the fields of neurology, pain management, medical oncology, psychiatry, infectious disease, family medicine, and gynecology.

F. "Applicant" means any person applying for enrollment or re-enrollment in the medical cannabis program as a qualified patient, primary caregiver, or licensed producer.

G. "Approved laboratory" means a laboratory that has been approved by the department specifically for the testing of cannabis, concentrates, and cannabis derived products.

H. "Batch" means, with regard to usable cannabis, a homogenous, identified quantity of cannabis no greater than five pounds that is harvested during a specified time period from a specified cultivation area, and with regard to concentrated and cannabis-derived product, means an identified quantity that is uniform, that is intended to meet specifications for identity, strength, and composition, and that is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling protocol.

I. "Cannabidiol ("CBD")" is a cannabinoid and the primary non-psychoactive ingredient found in cannabis.

J. "Cannabis" means all parts of the plant, cannabis sativa, and cannabis indica, whether growing or not and the resin extracted from any part of the plant.

K. "Cannabis-derived product" means a product, other than cannabis itself, which contains or is derived from cannabis, not including hemp.

L. "Concentrated cannabis-derived product ("concentrate")" means a cannabis-derived product that is manufactured by a mechanical or chemical process that separates any cannabinoid from the cannabis plant, and that contains (or that is intended to contain at the time of sale or distribution) no less than thirty-percent (30%) THC by weight.

M. "Courier" means a person or entity that transports usable cannabis within the state of New Mexico from a licensed non-profit producer to a qualified patient or primary caregiver, to another non-profit producer, to an approved laboratory, or to an approved manufacturer.

N. "Debilitating medical condition" means:

(1) cancer;

(2) glaucoma;

(3) multiple sclerosis;

(4) damage to the nervous tissue of the spinal cord, with objective neurological indication of intractable spasticity;

(5) epilepsy;

(6) positive status for human immunodeficiency virus or acquired immune deficiency syndrome;

(7) admission into hospice care in accordance with rules promulgated by the department; or

(8) any other medical condition, medical treatment, or disease as approved by the department which results in pain, suffering, or debility for which there is credible evidence that medical use cannabis could be of benefit.

O. "Department" means the department of health or its agent.

P. "Facility" means any building, space, or grounds licensed for the production, possession, testing, manufacturing, or distribution of cannabis, concentrates, or cannabis-derived products.

Q. "Intrastate" means existing or occurring within the state boundaries of New Mexico.

R. "Laboratory applicant" means a laboratory that seeks to become an approved laboratory, or that seeks renewal of approval as an approved laboratory, in accordance with this rule.

S. "License" means the document issued by the department granting the legal right to produce medical cannabis for a specified period of time.

T. "Licensed producer" means a person or entity licensed to produce medical cannabis.

U. "Licensure" means the process by which the department grants permission to an applicant to produce cannabis.

V. "Lot" means an identified portion of a batch, that is uniform and that is intended to meet specifications for identity, strength, and composition; or, in the case of a cannabis-derived product or concentrate, an identified quantity produced in a specified period of time in a manner that is uniform and that is intended to meet specifications for identity, strength, and composition.

W. "Male plant" means a male cannabis plant.

X. "Manufacture" means to make or otherwise produce cannabis-derived product or concentrate.

Y. "Manufacturer" means a business entity that manufactures cannabis-derived product that has been approved for this purpose by the medical cannabis program.

Z. "Mature female plant" means a harvestable female cannabis plant that is flowering.

AA. "Medical cannabis program" means the administrative body of the department charged with the management of the medical cannabis program and enforcement of program regulations, to include issuance of registry identification cards, licensing of producers, and regulation of manufacturing and distribution.

BB. "Medical cannabis program manager" means the administrator of the medical cannabis program who holds that title.

CC. "Medical director" means a medical practitioner designated by the department to determine whether the medical condition of an applicant qualifies as a debilitating medical condition eligible for enrollment in the program, and to perform other duties.

DD. "Medical provider certification for patient eligibility form" means a written certification form provided by the medical cannabis program signed by a patient's practitioner that, in the practitioner's professional opinion, the patient has a debilitating medical condition as defined by the act or this part and would be anticipated to benefit from the use of cannabis.

EE. "Minor" means an individual less than 18 years of age.

FF. "Paraphernalia" means any equipment, product, or material of any kind that is primarily intended or designed for use in compounding, converting, processing, preparing, inhaling, or otherwise introducing cannabis or its derivatives into the human body.

GG. "Patient enrollment/ re-enrollment form" means the registry identification card application form for patient applicants provided by the medical cannabis program.

HH. "Personal production license" means a license issued to a qualified patient participating in the medical cannabis program, to permit the qualified patient to produce

medical cannabis for the qualified patient's personal use, consistent with the requirements of department rule.

II. "Petitioner" means any New Mexico resident or association of New Mexico residents petitioning the advisory board for the inclusion of a new medical condition, medical treatment, or disease to be added to the list of debilitating medical conditions that qualify for the use of cannabis.

JJ. "Plant" means any cannabis plant, cutting, or clone that has roots or that is cultivated with the intention of growing roots.

KK. "Policy" means a written statement of principles that guides and determines present and future decisions and actions of the licensed producer.

LL. "Practitioner" means a person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act, Sections 30-31-1 *et seq.*, NMSA 1978.

MM. "Primary caregiver" means a resident of New Mexico who is at least 18 years of age and who has been designated by the qualified patient or their representative and the patient's practitioner as being necessary to take responsibility for managing the well-being of a qualified patient with respect to the medical use of cannabis pursuant to the provisions of the Lynn and Erin Compassionate Use Act, Section 26-2B-1 *et seq*., NMSA 1978.

NN. "Primary caregiver application form" means the registry identification card application form provided by the medical cannabis program.

OO. "Private entity" means a private, non-profit organization that applies to become or is licensed as a producer and distributor of cannabis, concentrates, or cannabis-derived products.

PP. "Proficiency testing" means testing conducted by the department or its agent to determine the ability of a laboratory applicant or approved laboratory to accurately identify presence, quantity, or other factors pertaining to a given analyte.

QQ. "Qualified patient" means a resident of New Mexico who has been diagnosed by a practitioner as having a debilitating medical condition and has received a registry identification card issued pursuant to the requirements of the act or department rules.

RR. "Registry identification card" means a document issued and owned by the department which identifies a qualified patient authorized to engage in the use of cannabis for a debilitating medical condition or a document issued by the department which identifies a primary caregiver authorized to engage in the intrastate possession and administration of cannabis for the sole use of the qualified patient.

SS. "Representative" means an individual designated as the applicant's or petitioner's agent, guardian, surrogate, or other legally appointed or authorized health care decision maker.

TT. "Secretary" means the secretary of the New Mexico department of health.

UU. "Secure grounds" means a facility that provides a safe environment to avoid loss or theft.

VV. "Security alarm system" means any device or series of devices capable of alerting law enforcement , including, but not limited to, a signal system interconnected with a radio frequency method such as cellular, private radio signals, or other mechanical or electronic device used to detect or report an emergency or unauthorized intrusion.

WW. "Security policy" means the instruction manual or pamphlet adopted or developed by the licensed producer containing security policies, safety and security procedures, and personal safety and crime prevention techniques.

XX. "Seedling" means a cannabis plant that has no flowers.

YY. "Segregate" means to separate and withhold from use or sale batches, lots, cannabis, usable cannabis, or cannabis-derived products in order to first determine its suitability for use through testing by an approved laboratory.

ZZ. "THC" means tetrahydrocannabinol, a cannabinoid that is the primary psychoactive ingredient in cannabis.

AAA. "Technical evidence" means scientific, clinical, medical, or other specialized testimony, or evidence, but does not include legal argument, general comments, or statements of policy or position concerning matters at issue in the hearing.

BBB. "Testing" means the process and procedures provided by an approved laboratory for testing of cannabis and cannabis derived products, consistent with provisions of this rule.

CCC. "Unit" means a quantity of usable cannabis, concentrate, or cannabis-derived product that is used in identifying the maximum supply that a qualified patient may possess for purposes of department rules.

DDD. "Usable cannabis" means the dried leaves and flowers of the female cannabis plant and cannabis-derived products, including concentrates, but does not include the seeds, stalks, or roots of the plant.

[7.34.3.7 NMAC - Rp, 7.34.3.7 NMAC, 2/27/2015; A, 2/29/2016]

7.34.3.8 QUALIFYING DEBILITATING MEDICAL CONDITIONS:

A. Statutorily-approved conditions: As of the date of promulgation of this rule, specific qualifying debilitating medical conditions, diseases, and treatments ("qualifying conditions") identified in the Lynn and Erin Compassionate Use Act, Section 26-2B-3(B) NMSA 1978, include:

(1) cancer;

(2) glaucoma;

(3) multiple sclerosis;

(4) damage to the nervous tissue of the spinal cord, with objective neurological indication of intractable spasticity;

(5) epilepsy;

(6) positive status for human immunodeficiency virus or acquired immune deficiency syndrome; and

(7) admission into hospice care in accordance with rules promulgated by the department.

B. Department-approved conditions: The department finds that the following additional qualifying conditions result in pain, suffering, or debility for which there is credible evidence that the medical use of cannabis could be of benefit, through the alleviation of symptoms, and the department accordingly approves these conditions as qualifying debilitating medical conditions for the participation of a qualified patient or primary caregiver in the medical cannabis program. The department-approved conditions include:

(1) severe chronic pain:

(a) objective proof of the etiology of the severe chronic pain shall be included in the application; and

(b) a practitioner familiar with the patient's chronic pain shall provide written certification that the patient has an

unremitting severe chronic pain condition; [~~for an initial patient application, this certification shall be made by a specialist with expertise in pain management or a specialist with expertise in the disease process that is causing the pain; for all subsequent patient applications, this certification may be made by a primary care provider.~~]

(2) painful peripheral neuropathy: application to the medical cannabis program shall be accompanied by medical records that confirm the objective presence of painful peripheral neuropathy [~~that has been refractory to other treatments~~];

(3) intractable nausea/vomiting;

(4) severe anorexia/cachexia;

(5) hepatitis C infection currently receiving antiviral treatment: the written certification shall attest:

(a) that the hepatitis C infection is currently being treated with antiviral drugs; and

(b) to the anticipated duration of the hepatitis C antiviral treatment.

(6) Crohn's disease;

(7) post-traumatic stress disorder (PTSD): each individual applying to the program for enrollment shall submit medical records that confirm [~~the~~] a diagnosis of PTSD [~~based upon the evaluation of a psychiatrist, psychiatric nurse practitioner, or prescribing psychologist, and~~] meeting the diagnostic criteria of the current *diagnostic and statistical manual of mental disorders*;

(8) inflammatory autoimmune-mediated arthritis: each individual applying to the program for enrollment shall submit medical records that confirm the diagnosis of inflammatory autoimmune-mediated arthritis [~~based upon the evaluation of a rheumatologist who is board-certified in rheumatology by the American board of internal medicine~~];

(9) amyotrophic lateral sclerosis (Lou Gehrig's disease);

(10) inclusion body myositis;

(11) spasmodic torticollis (cervical dystonia);

(12) Parkinson's disease;

(13) Huntington's disease;

(14) ulcerative colitis; and

(15) such other conditions as the secretary may approve.

C. Additional application requirements [~~for department-approved conditions~~]: A patient [~~applying on the basis of having a department-approved qualifying condition~~] shall submit written certification from the patient's practitioner which shall attest:

(1) to the diagnosis of the medical condition;

(2) that the condition is debilitating; and

(3) **[**~~that standard treatments have failed to bring adequate relief, unless the practitioner determines that standard treatments would be harmful to the patient's health; and~~

~~**(4)**~~] that potential risks and benefits of the use of medical cannabis for the condition have been discussed with the patient, in accordance with this rule; a patient who applies on the basis of having a department-approved condition may also be required to satisfy additional eligibility criteria, as specified in this rule.

D. Modification or removal of department-approved conditions: The secretary may remove or modify a department-approved condition only if the secretary determines, on the basis of substantial credible medical and scientific evidence, and after an opportunity for review of the proposed removal or modification by the medical advisory board, that the use of cannabis by patients who have the approved condition would more likely than not result in substantial harm to the patients' health. [7.34.3.8 NMAC - N, 2/27/2015; A, 2/29/2016]

7.34.3.16 DISCIPLINARY ACTIONS AND APPEAL PROCESS:

A. Grounds for disciplinary action: Disciplinary action may be taken against a qualified patient, patient-applicant, primary caregiver, or primary caregiver-applicant. Disciplinary action may include revocation, suspension, or denial, summary suspension, summary revocation, and other action. Disciplinary action may be imposed for:

(1) failure to comply with or satisfy any provision of this rule;

(2) falsification or misrepresentation of any material or information submitted to the department;

(3) failing to allow or impeding a monitoring visit by authorized representatives of the department;

(4) failure to adhere to any acknowledgement, verification, or other representation made to the department;

(5) failure to submit or disclose information required by this rule or otherwise requested by the department;

(6) failure to correct any violation of this rule cited as a result of a monitoring visit;

(7) diversion of cannabis or a cannabis-derived product, as determined by the department;

(8) threatening or harming a patient, a medical practitioner, or an employee of the department;

(9) **[**~~for primary caregivers: any determination by the primary caregiver's licensing body that the primary caregiver has engaged in unprofessional or dishonorable conduct;~~

~~**(10)**~~] for primary caregivers: conviction of the primary caregiver of any of the disqualifying convictions identified by department rule;

[~~**(11)**~~] **(10)** for patients: failure of the patient to satisfy any criterion identified as a prerequisite to eligibility for a condition approved by the department;

[~~**(12)**~~] **(11)** for patients: if a certifying provider of the patient determines that the use of cannabis by the patient would more likely than not be detrimental to the patient's health; and

[~~**(13)**~~] **(12)** any other basis identified in this rule.

B. Request for hearing: A qualified patient or primary caregiver who is the subject of disciplinary action, or an applicant who has received a notice of contemplated action to deny their application for any reason other than failure to submit a completed application or failure to meet a submittal requirement of this rule, may request a hearing in writing. The appellant shall file the request for hearing within 30 calendar days of the date the action is taken or the notice of contemplated action is received. The request shall:

(1) be properly addressed to the medical cannabis program;

(2) state the requestor's name, address, and telephone numbers; and

(3) include a statement of the issues that the appellant

considers relevant to the review of the action.

C. Hearing process:

(1) All formal adjudicatory hearings held pursuant to this regulation shall be conducted by a hearing examiner appointed by the secretary.

(2) Hearings shall be conducted in Santa Fe, New Mexico, or, with the consent of the parties, at another location.

(3) Due to federal and state laws regarding the confidentiality of protected health information, all hearings held pursuant to this section shall be closed to the public.

(4) The hearing shall be recorded on audiotape or other means of sound reproduction.

(5) Any hearing provided for in this rule may be held telephonically, with the consent of the parties.

D. Scheduling: The department shall schedule and hold the hearing no later than 60 calendar days from the date the department receives the appellant's request for hearing. The hearing examiner may extend the 60 day time period for good cause shown, or the parties may extend that period by mutual agreement. The department shall issue notice of the hearing, which shall include:

(1) a statement of the time, place, and nature of the hearing;

(2) a statement of the legal authority and jurisdiction under which the hearing is to be held; and

(3) a short and plain statement of the subject of the hearing.

E. Presentation of evidence: All parties shall be given the opportunity to respond and present evidence and argument on relevant issues.

F. Record of proceeding: The record of the proceeding shall include the following:

(1) all pleadings, motions, and rulings;

(2) evidence and briefs received or considered;

(3) a statement of any matters officially noticed;

(4) offers of proof, objections, and rulings thereon;

(5) proposed findings and conclusions; and

(6) any action recommended by the hearing examiner.

G. Audio recording: A party may request a copy of the audio recording of the proceedings.

H. Procedures and evidence:

(1) a party may be represented by a person licensed to practice law in New Mexico or a non-lawyer representative, or may represent himself or herself;

(2) the rules of evidence as applied in the courts do not apply in these proceedings; any relevant evidence shall be admitted; irrelevant, immaterial, or unduly repetitious evidence may be excluded;

(3) the experience, technical competence, and specialized knowledge of the hearing examiner, the department or the department's staff may be used in the evaluation of evidence;

(4) an appellant's failure to appear at the hearing at the date and time noticed for the hearing shall constitute a default.

I. Conduct of proceeding: Unless the hearing examiner determines a different procedure to be appropriate, the hearing shall be conducted as follows:

(1) the appellant may present an opening statement and the department may present an opening statement or reserve the statement until presentation of its case;

(2) upon conclusion of any opening statements, the appellant shall present his or her case;

(3) upon the conclusion of the appellant's case, the department shall present its case;

(4) upon conclusion of either party's case, the opposing party may present rebuttal evidence; and

(5) after presentation of the evidence by the parties, the parties may present closing arguments.

J. Burden of proof: The appellant bears the burden of establishing by a preponderance of the evidence that the decision made or proposed by the department should be reversed or modified.

K. Continuances: The hearing examiner may grant a continuance for good cause shown. A motion to continue a hearing shall be made at least 10 calendar days before the hearing date.

L. Telephonic hearings:

(1) any party requesting a telephonic hearing shall do so no less than 10 business days prior to the date of the hearing; notice of the telephonic hearing shall be given to all parties and shall include all necessary telephone numbers;

(2) failure of an appellant to provide their correct telephone number or failure to be available at the commencement of the hearing shall be treated as a failure to appear and shall constitute a default;

(3) the in-person presence of some parties or witnesses at the hearing shall not prevent the participation of other parties or witnesses by telephone with prior approval of the hearing examiner.

M. Recommended action and final decision:

(1) the parties may submit briefs including findings of fact and conclusions of law for consideration by the hearing examiner;

(2) no later than 30 calendar days after the last submission by a party, the hearing examiner shall prepare and submit to the secretary a written recommendation of action to be taken by the secretary; the recommendation shall propose sustaining, reversing, or modifying the proposed action of the department;

(3) the secretary shall issue a final written decision accepting or rejecting the hearing examiner's recommendation in whole or in part no later than 30 calendar days after receipt of the hearing examiner's recommendation; the final decision shall identify the final action taken; service of the secretary's final decision shall be made upon the appellant by registered or certified mail;

(4) the final decision or order shall be made a part of the patient or primary caregiver's file with the medical cannabis program.

[7.34.3.16 NMAC - Rp, 7.34.3.14 NMAC, 2/27/2015; A, 2/29/2016]

HEALTH, DEPARTMENT OF

Explanatory Paragraph: This is an amendment to 7.34.4 NMAC, Section 7, 8, 9, 14, 15, 17, 19 and 26, effective 2/29/2016. In 7.34.4.7 NMAC, Subsections A, B, D through G, I through L and N through DDD; 7.34.4.8 NMAC, Subsections A through D and F through W; 7.34.4.9 NMAC, Subsections A, D & E; 7.34.4.15 NMAC, Subsections B, D, E, G through I; 7.34.4.17 NMAC, Subsections B, D through G; 7.34.4.19 NMAC, Subsections A through I, K & L were not published as there were no changes.

7.34.4.7 DEFINITIONS:

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C. "Administrative review committee" means an intra-department committee that reviews qualified patient or primary caregiver application denials, licensed producer denials made by the program manager, or the [~~imposition of a~~] summary suspension of a producer's license, in accordance with department rules. The administrative review committee shall consist of the chief medical officer of the department (or that's person's designee); a deputy secretary of the department (or that person's designee), and the chief nursing officer of the department (or that person's designee).

***

H. "Batch" means, with regard to usable cannabis, a homogenous, identified quantity of cannabis no greater than five pounds that is harvested during a specified time period from a specified cultivation area, and with regard to concentrated and cannabis-derived product, means an identified quantity that is uniform, that is intended to meet specifications for identity, strength, and composition, and that is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling protocol.

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M. "Courier" means a person or entity that transports usable cannabis within the state of New Mexico from a licensed non-profit producer to a qualified patient or primary caregiver, to another non-profit producer, to an approved laboratory, or to an approved manufacturer.
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[7.34.4.7 NMAC - Rp, 7.34.4.7 NMAC, 2/27/2015; A, 2/29/2016]

7.34.4.8 PRODUCER LICENSING; GENERAL PROVISIONS:

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E. Production and distribution of medical cannabis by a licensed non-profit producer; use of couriers: Production and distribution of medical cannabis by a licensed non-profit producer to a qualified patient or primary caregiver shall take place at locations described in the non-profit producer's production and distribution plan approved by the department, and shall not take place at locations that are within 300 feet of any school, church, or daycare center. For purposes of this [~~rule~~] provision, delivery to the residence of a qualified patient or primary caregiver shall not be deemed "distribution". A licensed non-profit producer may, consistent with this rule, and with the consent of a purchasing qualified patient or primary caregiver, utilize an approved courier to transport usable cannabis to a qualified patient or primary caregiver, and may for this purpose share with an approved courier the contact information of the purchasing qualified patient or primary caregiver. A licensed non-profit producer may, consistent with this rule, also utilize an approved courier to transport usable cannabis to another non-profit producer, to an approved laboratory, and to an approved manufacturer. A licensed non-profit producer shall not identify any person as an intended recipient of usable cannabis who is not [~~either~~] a qualified patient [~~or~~], a primary caregiver, an approved courier, an approved manufacturer, or an approved laboratory.

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[7.34.4.8 NMAC - Rp, 7.34.4.8 NMAC, 2/27/2015; A, 2/29/2016]

7.34.4.9 NON-PROFIT PRODUCER TESTING OF USABLE CANNABIS: All dried usable cannabis and all concentrated cannabis derived products produced, sold, or distributed by a non-profit producer shall be sampled for testing purposes by the licensed non-profit producer, and those samples shall be tested by an approved laboratory, consistent with the requirements of this rule, prior to the sale or distribution of the dried usable cannabis or concentrated cannabis derived product. Each batch of dried usable cannabis or cannabis concentrate shall be segregated and sampled, and each sample shall be tested by an approved laboratory in accordance with the testing requirements of this rule, and determined by the licensed non-profit producer to have passed the following individual testing requirements, before dried usable cannabis or cannabis concentrate from that batch is made available for sale or distribution.

***

B. Exception for previously tested cannabis: A non-profit producer shall not be required to sample and test cannabis or a concentrated cannabis-derived product if the batch was previously sampled, and the sample was tested by another non-profit producer in accordance with this rule and determined to have passed the testing requirements of this rule.

C. Individual testing requirements:

(1) Microbiological test: A non-profit producer shall sample and test dried, usable cannabis and concentrated cannabis derived products for microbiological contaminants, using an approved laboratory. A dried cannabis sample may be deemed to have passed the microbiological test if it satisfies the standards set forth in Section 2023 of the United States Pharmacopeia ("microbiological attributes of non-sterile nutritional and dietary supplements"), which can be obtained at http://www.usp.org.

(2) Mycotoxin test: A non-profit producer shall sample and test dried, usable cannabis and concentrated cannabis derived products for mycotoxins, using an approved laboratory. A sample may be deemed to have passed the mycotoxin test if the total quantity of aflatoxin B1, B2, G1, and G2 and ochratoxin A is collectively less than 20 µg/kg (parts per billion) of the sample.

(3) Solvent residue test: A non-profit producer shall sample and test all concentrated cannabis derived products that are manufactured using solvent extraction methods for the presence of solvent residue, using an approved laboratory. A non-profit producer shall determine on the basis of the solvent residue test results whether the quantity of solvent residue contained within a concentrated cannabis derived product poses a health risk to consumers. A non-profit producer shall not sell or distribute a concentrated cannabis derived product from a batch that is found to contain a quantity of solvent residue that is likely to be harmful to human health.

(4) [~~Heavy metals test:~~ ~~A non-profit producer shall sample and test dried, usable cannabis and concentrated cannabis derived products for heavy metals. A sample may be deemed to have passed the heavy metals test if the total quantity of arsenic is less than 0.14 µg/kg (parts per billion); if the total quantity of cadmium is less than 0.09 µg/kg; if the total quantity of lead~~

~~is less than 0.29 µg/kg; and if the total quantity of mercury is less than 0.29 µg/kg. Exception: a non-profit producer that grows cannabis in a hydroponic system utilizing either a municipal water supply or a water filtering system sufficient to filter the contaminants identified above shall not be subject to heavy metals test requirements.~~

~~(5)]~~ **Quantity of THC and CBD:** A non-profit producer shall sample and test all dried usable cannabis and concentrated cannabis derived products for quantity of THC and CBD, using an approved laboratory, prior to sale, distribution, or other use.

[~~(6)]~~ **(5) Additional testing:** The department may require additional testing of cannabis and cannabis derived products by non-profit producers, as it deems appropriate.

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[7.34.4.9 NMAC - Rp, 7.34.4.8 NMAC, 2/27/2015; A, 2/29/2016]

7.34.4.14 LABELING OF USABLE CANNABIS: A non-profit producer shall not sell or otherwise distribute a usable cannabis product that has not been packaged and labeled in accordance with this rule. The label shall identify:

A. the name of the entity that produced the cannabis, and the name of the manufacturer of the cannabis-derived product (as applicable);

B. a batch number or code;

C. a production date or expiration date, including a "use by" or "freeze by" date for products capable of supporting the growth of infectious, toxigenic, or spoilage microorganisms;

D. the number of units of usable cannabis or concentrated cannabis-derived product contained within the product, as identified in department rules for the enrollment of qualified patients;

E. for dried, usable cannabis: the quantity of THC and CBD, which shall be expressed by weight;

F. for concentrated cannabis derived product: the quantity of THC and CBD, which shall be expressed by weight and by percentage of total weight;

G. pesticide(s) used in the production of the cannabis or cannabis-derived product;

H. instructions for use;

[~~H.~~] **I.** warnings for use;

[~~I.~~] **J.** instructions for appropriate storage;

[~~J.~~] **K.** approved laboratory analysis, including the results of strength and composition within ten percent (10%) of numbers shown on the package;

[~~K.~~] **L.** the name of the strain, product facts, or a nutrition fact panel, and a statement that the product is for medical use by qualified patients, to be kept away from children, and not for resale;

[~~L.~~] **M.** whether the batch from which the product was derived was sampled and tested by an approved laboratory; and

[~~M.~~] N. the name of the department approved testing facility used for active ingredient analysis, and quantity of THC and CBD (as applicable).

[7.34.4.14 NMAC - N, 2/27/2015; A, 2/29/2016]

7.34.4.15 DEPARTMENT-APPROVED TESTING LABORATORIES; GENERAL PROVISIONS: A laboratory applicant shall comply with the application requirements of this rule, and shall submit such other information as the laboratory applicant wishes to provide or such information as the department may request for initial approval and periodic evaluations during the approval period.

A. Testing categories: A laboratory may apply to become approved by the department as an approved laboratory for the testing of cannabis and cannabis derived products in all or any one of the following categories:

(1) mycotoxin analysis;

(2) microbiological contaminant analysis;

(3) solvent residue analysis;

(4) [~~heavy metals analysis;~~

~~(5)~~] quantity of THC and CBD; and

[~~(6)~~] **(5)** such other testing categories as the department may identify.

***

C. Application materials: A laboratory applicant shall submit to the program with each initial application and renewal application for continued approval the following:

(1) standard operating procedures to be followed by the laboratory, including but not limited to policies and procedures to be used in performing analysis of samples;

(2) a description of the type of tests to be conducted by the laboratory applicant, which may include, but are not limited to, testing for microbiological contaminants, mycotoxins, solvent residue, [~~heavy metals,~~] THC content, CBD content, identity, purity, strength, composition, or nutritional content, and other quality factors;

(3) quality control criteria for the test(s) that the applicant intends to conduct;

(4) evidence that validates the accuracy of the test(s) to be conducted by the laboratory applicant as performed in the applicant's laboratory;

(5) proof that the laboratory applicant is in good standing with the New Mexico taxation and revenue department;

(6) copies of the laboratory applicant articles of incorporation and by-laws, as applicable;

(7) a list of all persons or business entities having direct or indirect authority over the management or policies of the laboratory applicant;

(8) a list of all persons or business entities having any ownership interest in any property utilized by the laboratory applicant, whether direct or indirect, and whether the interest is in land, building(s), or other material, including owners of any business entity that owns all or part of land or building(s) utilized;

(9) a description of the facilities and equipment that shall be used in the operation of the laboratory applicant;

(10) a description of how the laboratory applicant will ensure and document chain of custody of any samples held or tested by the laboratory;

(11) a general written security policy, to address at a minimum safety and security procedures;

(12) an attestation that no firearms will be permitted on any premises used by the laboratory applicant;

(13) a description of the methods and device or series of devices that shall be used to provide security;

(14) training documentation prepared for each employee of the laboratory applicant, statements signed by employees indicating the topics discussed (to include names and titles of presenters) and the date, time, and place the employee received said training;

(15) personnel records for each employee of the manufacturer applicant that include an application for employment and a record of any disciplinary action taken;

(16) employee safety and security training materials provided to each employee of the manufacturer applicant at the time of his or her initial appointment, to include training in the proper use of security measures and controls that have been adopted, and specific procedural instructions regarding how to respond to an emergency, including robbery or a violent accident; and

(17) such other materials as the department may require.

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F. Retention and inspection of testing records: An approved laboratory shall [~~maintain~~] retain all results of laboratory tests conducted on cannabis or cannabis derived products for a period of at least two years and shall make them available to the program upon the program's request.

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[7.34.4.15 NMAC - N, 2/27/2015; A, 2/29/2016]

7.34.4.17 DEPARTMENT-APPROVED COURIERS; GENERAL PROVISIONS:

A. Approval of couriers: The department may approve a courier for the purpose of transporting usable cannabis from one or more licensed non-profit producers to qualified patients, [~~and~~] primary caregivers, other non-profit producers, approved manufacturers and approved laboratories.

***

C. General requirements: An approved courier shall adhere to each of the following requirements:

(1) a courier may contract with a licensed non-profit producer to deliver usable cannabis from the non-profit producer to [~~a~~] qualified [~~patient or~~] patients, primary [~~caregiver~~] caregivers, other non-profit producers, approved manufacturers and approved laboratories; a courier that provides service to more than one licensed non-profit producer shall offer their service at a uniform price for all non-profit producers for whom they deliver; an approved courier shall not transport a cannabis product that is not individually packaged, or that is not labeled in accordance with this rule;

(2) an approved courier shall not request or receive payment from a qualified patient or primary caregiver [~~; a courier may collect any applicable fee from a licensed non-profit producer~~];

(3) upon obtaining a package of usable cannabis from a licensed non-profit producer, an approved courier shall hold the package in a secured area or areas that are locked and otherwise resistant to tampering or theft, until the package is delivered to its intended recipient or returned to the licensed non-profit producer;

(4) an approved courier shall not relinquish possession of usable cannabis [~~that is intended for delivery to a qualified patient or primary caregiver~~] unless and until the package of usable cannabis is either successfully delivered or returned to the licensed non-profit producer; for purposes of this section, a package of usable cannabis is successfully delivered only upon the approved courier's verification that an intended recipient has taken actual, physical possession of the package; an approved courier shall not leave a package at any location for any reason, unless the package is successfully delivered to its intended recipient;

(5) an approved courier shall not deliver a package to any person or entity who is not identified by [~~a selling~~] the licensed non-profit producer as [~~a purchasing qualified patient or primary caregiver~~] an intended, authorized recipient;

(6) at the time of delivery, an approved courier shall verify the recipient's identity by requiring presentation of the [~~qualified patient's or primary caregiver's~~] recipient's department-issued medical cannabis identification card and New Mexico-issued photo identification card or a passport; an approved courier shall not deliver usable cannabis to any person whose identity is not verified in accordance with this rule; an approved courier shall document having verified the recipient's identification in accordance with this rule for each transaction;

(7) an approved courier shall not possess usable cannabis for a time period greater than seven days; an approved courier shall return any usable cannabis that is not successfully delivered to its intended recipient to a licensed non-profit producer within this time period;

(8) an approved courier shall not distribute cannabis at locations that are within 300 feet of a school, church, or daycare center; provided that, for purposes of this [~~rule~~] provision, delivery to the residence of a qualified patient or primary caregiver shall not be deemed "distribution";

(9) an approved courier and its personnel shall at all times take measures to ensure confidentiality and safety in the transport and delivery of usable cannabis [~~to a qualified patient or primary caregiver~~];

(10) an approved courier shall appropriately train its personnel regarding the confidentiality of information concerning qualified patients and primary caregivers; confidentiality training shall describe confidentiality requirements applicable under both federal and state law; an approved courier shall conduct confidentiality training of its personnel at least once annually, and shall maintain training materials on its premises, and document the training of individual staff; and

(11) personnel of an approved courier shall not possess a firearm while distributing or otherwise possessing cannabis; an approved courier shall not possess or permit the possession of a firearm on any premises, including a building or vehicle, utilized by the courier.

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[7.34.4.17 NMAC - N, 2/27/2015; A, 2/29/2016]

7.34.4.19 NON-PROFIT PRODUCER APPLICATION AND LICENSURE REQUIREMENTS: An applicant for initial or renewal non-profit producer licensure shall provide materials and information to the department, in accordance with the provisions of this section, in order to be considered for a license to produce medical cannabis. A licensed non-profit producer shall also promptly submit revised versions of any such materials in the event that the materials or their content change.

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J. Patient identification and sales records: A licensed non-profit producer shall retain clear, legible photocopies or electronic copies of [~~all~~] current registry identification cards and current New Mexico photo identification

cards of all qualified patients and primary caregivers served by the non-profit entity. A licensed non-profit producer shall also create and retain materials that document every instance in which usable cannabis was sold or otherwise distributed to another person or entity, including documentation of the recipient, type, quantity, and batch of the usable cannabis.

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[7.34.4.19 NMAC - Rp, 7.34.4.8 & 10 NMAC, 2/27/2015; A, 2/29/2016]

7.34.4.26 [~~LICENSED PRODUCER AND PRODUCER-APPLICANT~~] PERSONAL PRODUCTION LICENSE CONFIDENTIALITY:

[~~A.~~] Personal production license holders and applicants: The department shall maintain a confidential file containing the names, addresses, and telephone numbers of the persons [~~or entities~~] who have either applied for or received a personal production license (PPL) [~~for the purpose of producing and distributing cannabis for medical use~~]. Individual names of PPL producers and PPL producer-applicants shall be confidential and not subject to disclosure, except:

[~~(1)~~] A. to authorized employees or agents of the department as necessary to perform the duties of the department pursuant to the provisions of this rule and the act;

[~~(2) to state or local regulatory agencies and entities, for purposes related to those agencies' or entities' duties under applicable law;~~

~~(3)~~] B. to authorized employees of state or local law enforcement agencies, but only for the purpose of verifying that a person is lawfully in possession of the license to produce, or as otherwise expressly permitted in this rule; and

[~~(4)~~] C. as provided in the federal Health Insurance Portability and Accountability Act of 1996.

[~~B. A pending application for licensure as a non-profit producer shall be confidential and not subject to disclosure.~~]

[7.34.4.26 NMAC - Rp, 7.34.4.18 NMAC, 2/27/2015; A, 2/29/2016]

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

The Human Services Department approved, at its 1/4/2016 hearing, to repeal its rule 8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver (filed 10/2/2012) and replace it with 8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, effective 3/1/2016.

The Human Services Department approved, at its 1/4/2016 hearing, to repeal its rule 8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver (filed 10/2/2012) and replace it with 8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, effective 3/1/2016.

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, 3/1/2016]

8.314.5.2 SCOPE: The rule applies to the general public.
[8.314.5.2 NMAC - Rp, 8.314.5.2 NMAC, 3/1/2016]

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 Section 27-2-12 et seq. NMSA 1978.
[8.314.5.3 NMAC - Rp, 8.314.5.3 NMAC, 3/1/2016]

8.314.5.4 DURATION: Permanent.
[8.314.5.4 NMAC - Rp, 8.314.5.4 NMAC, 3/1/2016]

8.314.5.5 EFFECTIVE DATE: March 1, 2016, unless a later date is cited at the end of a section.
[8.314.5.5 NMAC - Rp, 8.314.5.5 NMAC, 3/1/2016]

8.314.5.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.314.5.6 NMAC - Rp, 8.314.5.6 NMAC, 3/1/2016]

8.314.5.7 DEFINITIONS:

A. Activities of daily living (ADLs): Those activities associated with an individual's daily functioning. The basic skills of everyday living such as toileting, bathing, dressing, grooming, and eating and the skills necessary to maintain the normal routines of the day, such as housekeeping, shopping and preparing meals. The term also includes exercising, personal, social and community skills.

B. Adult: An individual who is 18 years of age or older.

C. Authorized representative: An individual designated by the eligible recipient or his or her guardian, if applicable, to represent the eligible recipient and act on his or her behalf. The authorized representative must provide formal documentation authorizing him or her to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the eligible recipient's guardian or attorney.

D. Child: An individual under the age of 18. For purpose of early periodic screening, diagnosis and treatment (EPSDT) services eligibility, "child" is defined as an individual under the age of 21.

E. Clinical Documentation: Sufficient information and documentation that demonstrates the request for developmental disabilities waiver (DDW) services is necessary and appropriate based on the service specific DDW clinical criteria established by the department of health (DOH) developmental disabilities support division (DDSD) for adult recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990). Examples of clinical documentation include but are not limited to: the therapy service prior

authorization request (TSPAR), behavioral support consultation prior authorization request (BSCPAR), intense medical living service (IMLS) parameter tool, electronic comprehensive health assessment tool (e-Chat), assessments, clinical notes, progress notes, interdisciplinary team (IDT) meeting minutes, letters from physicians or ancillary service providers that provide sufficient clinical information that demonstrates the need for requested services, etc. Any relevant supporting information and documentation is acceptable and will be considered by the outside reviewer.

F. Clinical justification: Information and documentation that justifies the need for services based on the eligible recipient's assessed need and the DDW clinical criteria. Based on assessed need, the justification must:

(1) meet the eligible recipient's clinical, functional, physical, behavioral or habilitative needs;

(2) promote and afford support to the eligible recipient for his or her greater independence; or

(3) contribute to and support the eligible recipient's efforts to remain in the community; to contribute and be engaged in his or her community, and to reduce his or her risk of institutionalization; and

(4) address the eligible recipient's physical, behavioral, social support needs (not including financial support) that arise as a result of his or her functional limitations or conditions , such as: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(5) relate to an outcome in the eligible recipient's individual service plan (ISP).

G. DDW clinical criteria: A set of criteria established by the DOH that is applied by an outside reviewer to each DDW service when a DDW service is requested for adult recipients excluding a class member of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990).

H. Individual service plan (ISP): A treatment plan for an eligible recipient that includes his or her needs, functional levels, intermediate and long range goals statements for achieving his or her goals and specifies responsibilities for the eligible recipient's care needs. The ISP determines the services allocated to the eligible recipient within the DDW allowances.

I. Outside reviewer: An independent third party who conducts a clinical review of all requested DDW services. The outside reviewer will make a written determination on whether the requested supports are clinically justified and will recommend whether the eligible recipient's requested ISP and budget should be approved or denied. The decision of the outside reviewer to approve any requested service is binding on the state. However, the state may agree to overturn a decision to deny requested services.

J. Person centered planning: Addresses health and long-term services and support needs in an individualized manner that reflects the eligible recipient's preferences, strengths and goals.

K. Supports Intensity Scale® (SIS): A reliable, valid, standardized assessment designed to measure the pattern and intensity of supports needed for people (16 years or older) with intellectual/developmental disabilities (I/DD) to be successful in community settings. The SIS was developed by the American association on intellectual and developmental disabilities (AAIDD) between 1998 and 2003, with norms based on people with I/DD, 16 years or older, and was released for use in 2004. For the purpose of this definition, SIS includes all refreshed versions of the SIS such as the Supports Intensity Scale-Adult version ™ (SIS –A) that remain identical in reliability and validity to the original SIS.

L. Waiver: Permission from the centers for medicaid and medicare services (CMS) to cover a particular population or service not ordinarily allowed.

M. Young Adult: An individual between the ages of 18 through 20 years of age who is allocated to the DDW and is receiving specific services as identified in the DOH/DDSD standards and policies. An individual under age 21 is eligible for medical services funded by his or her medicaid providers under EPSDT. Upon the individual's 21st birthday, he or she is considered to be an adult recipient of DDW services.

[8.314.5.7 NMAC - Rp. 8.314.5.7 NMAC, 3/1/2016]

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, 3/1/2016]

8.314.5.9 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER: To help New Mexicans who have an I/DD or a specified related condition to receive services in a cost-effective manner, the New Mexico medical assistance division (MAD) has obtained a waiver from certain medicaid payment and benefit statutes (42 CFR 441.300) to provide home and community-based services (HCBS) to eligible recipients as an alternative to institutionalization. DDW 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.

[8.314.5.9 NMAC - Rp, 8.314.5.9 NMAC, 3/1/2016]

8.314.5.10 ELIGIBLE PROVIDERS:

A. Health care to MAP 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 (PPA) 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 MAP 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 New Mexico administrative code (NMAC) rules, billing instructions, utilization review instructions, service definitions and service standards 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 PPA 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. All DDW eligible providers must be approved by DOH or its designee and have an approved MAD PPA and a DOH provider agreement.

C. MAD through its designee, DOH/DDSD, follows a subcontractor model for certain DDW services. The agency, following the DOH/DDSD model, must ensure that its subcontractors or employees meet all required qualifications. The agency must provide oversight of subcontractors and employees to ensure that they meet all required MAD and DOH/DDSD qualifications. In addition, the agency must provide satisfactory oversight of subcontractors and employees to ensure that services are delivered in accordance with all requirements set forth by the DOH/DDSD DDW service definition, all requirements outlined in the DDW services standards, applicable NMAC rules, MAD supplements, and as applicable, his or her New Mexico licensing board's scope of practice and licensure. Pursuant to federal regulations, an agency may not employ or subcontract with the spouse of an eligible recipient or the parent of an eligible recipient under 18 years of age to provide direct care services to the eligible recipient.

D. Qualifications of case management provider agency: A case management provider agency, its case managers, whether subcontractors or employees must comply with 8.314.5.10 NMAC. In addition, case management provider agency must ensure that a case manager meets the following qualifications:

(1) one year of clinical experience, related to the target population; and

(2) one or more of the following:

(a) hold a current social worker license as defined by the New Mexico regulation and licensing department (RLD); or

(b) hold a current registered nurse (RN) license as defined by the New Mexico board of nursing; or

(c) hold a bachelor's or master's degree in social work, psychology, sociology, counseling, nursing, special education, or a closely related field; and

(3) comply with all training requirements as specified by DOH/DDSD; and

(4) have received written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS); and

(5) does not provide any direct support services through any other type of 1915 (c) Home and Community Based Waiver Program.

E. Qualifications of respite provider agency: A respite provider agency must comply and ensure that all direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. In addition, respite provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current cardiopulmonary resuscitation (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 CCHS.

F. Qualifications of adult nursing provider agencies: Adult nursing provider agencies must ensure it has subcontractors or employees, including nurses, comply with DOH DDW service definitions, DDW service standards, applicable NMAC rules, MAD billing instructions, utilization review instructions, and supplements, and applicable federal and state laws, rules and statutes. Direct nursing services shall be provided by a New Mexico licensed RN or licensed practical nurse (LPN) and must comply with all aspects of the New Mexico Nursing Practice Act, including requirements regarding delegation of specific nursing function and 8.314.5.10 NMAC.

G. Qualifications of therapy provider agency: A therapy provider agency must comply and ensure that each of its therapists including physical therapists (PT), occupational therapists (OT), and speech therapists (SLP), physical therapy assistants (PTA), and certified occupational therapy assistants (COTA), whether a subcontractor or employee complies with 8.314.5.10 NMAC.

H. Qualifications for community living supports provider agency: Living supports consist of family living, supported living, and intensive medical living services. A living supports provider agency must comply with the accreditation policy and all requirements set forth by the DOH, DDW service definitions, all requirements outlined in the DDW service standards and the applicable NMAC rules. A living supports provider agency must ensure that all direct support personnel meet all qualifications set forth by DOH, DDW service standards, and applicable NMAC rules.

(1) A living supports provider agency and direct support personnel must:

(a) comply with all training requirements as specified by DOH;

(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 CCHS.

(2) A family living provider agency must ensure that all direct support personnel, whether a subcontractor or employee, meet all qualifications set forth by DOH and the DDW service standards and the applicable NMAC rules. The direct support personnel employed by or subcontracting with the provider agency must be approved through a home study completed prior to the initiation of services and periodically thereafter as required of the provider agency.

(3) A supported living provider agency must ensure that all direct support personnel meet all qualifications set forth by DOH and the applicable NMAC rules and the DDW service standards. A supported living provider agency must employ or subcontract with at least one licensed RN and comply with the New Mexico Nurse Practicing Act, including requirements regarding delegation of specific nursing functions.

(4) An intensive medical living supports provider agency must employ or subcontract with at least one New Mexico licensed RN who must have a minimum of one year of supervised nursing experience and comply with the New Mexico Nursing Practice Act. An intensive medical living supports provider agency must comply with and ensure RNs, whether subcontractors or employees, comply with 8.314.5.10

NMAC. In addition, an intensive medical living supports provider agency and direct support personnel must:

(a) comply with all training requirements as specified by DOH;

(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 CCHS.

I. Qualifications of a customized community supports provider agency: A customized community supports provider agency must comply with and ensure that all direct support personnel comply with 8.314.5.10 NMAC. In addition, a customized community supports provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(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 CCHS.

J. Qualifications of a community integrated employment provider agency: A community integrated employment provider agency must comply with and ensure that all direct support personnel comply with 8.314.5.10 NMAC. In addition, a community integrated employment provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(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 CCHS.

K. Qualifications of a behavioral support consultation provider agency: A behavioral support consultation provider agency must comply with and ensure that all behavioral support consultants, whether subcontractors or employees, comply with 8.314.5.10 NMAC.

(1) A provider of behavioral support consultation services must be currently licensed in one of the following professions and maintain that licensure with the appropriate RLD board or licensing authority:

(a) a licensed mental health counselor (LMHC), or

(b) a licensed clinical psychologist; or

(c) a licensed psychologist associate, (masters or Ph.D. level); or

(d) a licensed independent social worker (LISW) or a licensed clinical social worker; or

(e) a licensed master social worker (LMSW); or

(f) a licensed professional clinical counselor (LPCC); or

(g) a licensed marriage and family therapist (LMFT); or

(h) a licensed practicing art therapist (LPAT); or

(i) Other related licenses and qualifications may be considered with DOH's prior written approval.

(2) Providers of behavioral support consultation services must have a minimum of one year of experience working with individuals with intellectual or developmental disabilities.

(3) Behavioral support consultation providers must participate in training in accordance with the DOH/DDSD training policy.

L. Qualifications of a nutritional counseling provider agency: A nutritional counseling provider agency must comply with and ensure that all nutritional counseling providers, whether subcontractors or employees comply with 8.314.5.10 NMAC. In addition, a nutritional counseling provider must be registered as a dietitian by the commission on dietetic registration of the American dietetic association and be licensed by RLD as a nutrition counselor.

M. Qualifications of an environmental modification provider agency: An environmental modification contractor and his or her subcontractors and employees must be bonded, licensed by RLD, and authorized by DOH to complete the specified project. An environmental modification provider agency must comply with 8.314.5.10 NMAC. All services shall be provided in accordance with applicable federal, state and local building codes.

N. Qualifications of a crisis supports provider agency: A crisis supports provider agency must comply with and must ensure that direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. In addition, a crisis supports provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(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 CCHS.

O. Qualifications for a non-medical transportation provider agency: A non-medical transportation provider agency must comply with 8.314.5.10 NMAC. In addition, a non-medical transportation provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(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 CCHS.

P. Qualifications of a supplemental dental care provider agency: A supplemental dental care provider agency must comply with 8.314.5.10 NMAC. A supplemental dental care provider must contract with a New Mexico licensed dentist and dental hygienist who are licensed by RLD. The supplemental dental care provider will ensure that a RLD licensed dentist provides the oral examination; ensure that a RLD licensed dental hygienist provides all routine dental cleaning services; demonstrate fiscal solvency; and function as a payee for the service.

Q. Qualifications of an assistive technology purchasing agent provider and agency: An assistive technology purchasing agent provider and agency must comply with 8.314.5.10 NMAC, demonstrate fiscal solvency and function as a payee for this service.

R. Qualifications of an independent living transition service provider agency: An independent living transition service provider agency must comply with 8.314.5.10 NMAC, demonstrate fiscal solvency and function as a payee for this service.

S. Qualifications of a

personal support technology/on-site response service provider agency: Personal support technology/on-site response service provider agencies must comply with 8.314.5.10 NMAC. In addition, personal support technology/on-site response service provider agencies must comply with all laws, rules, and regulations of the federal communications commission (FCC) for telecommunications.

T. Qualifications of a preliminary risk screening and consultation related to inappropriate sexual behavior (PRSC) provider agency: A PRSC provider agency must comply with 8.314.5.10 NMAC and all training requirements as specified by DOH. Additionally, the PRSC provider agency must subcontract with or employ the risk evaluator, who at a minimum must be:

(1) an RLD independently licensed behavioral health practitioner, such as an LPCC, LCSW, or a psychologist; or

(2) a practitioner who holds a master's or doctoral degree in a behavior health related field from an accredited college or university.

U. Qualifications of a socialization and sexuality education provider agency: A socialization and sexuality education provider agency must comply with 8.314.5.10 NMAC. A provider agency must be approved by the DOH, bureau of behavioral support (BBS) as a socialization and sexuality education provider, and must meet training requirements as specified by DOH. In addition, a socialization and sexuality education provider agency must employ or contract with a provider who has one of the following qualifications for 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 RN or LPN;

(7) a bachelor's degree in special education;

(8) a certification in special education; or

(9) a New Mexico level three recreational therapy instructional support provider certification.

V. Qualifications of a customized in-home supports provider agency: A customized in-home supports provider agency must comply with and ensure that direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. In addition, a customized in-home supports provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(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 CCHS.

[8.314.5.10 NMAC - Rp, 8.314.5.10 NMAC, 3/1/2016]

8.314.5.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations, rules, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement and the DOH provider agreement. A provider also must meet and adhere to all applicable NMAC rules and instructions as specified in the MAD provider rules manual and its appendices, DDW service standards, DDW service definitions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicare and medicaid services (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.

[8.314.5.11 NMAC - Rp, 8.314.5.11 NMAC, 3/1/2016]

8.314.5.12 ELIGIBLE RECIPIENTS: DDW services are intended for an eligible recipient who has a developmental disability limited to an I/DD, or a specific related condition. The MAP category of eligibility criteria for DDW services is located in 8.290.400 NMAC.

[8.314.5.12 NMAC - Rp, 8.314.5.12 NMAC, 3/1/2016]

8.314.5.13 RECIPIENT STANDARDIZED ASSESSMENT:

A. DOH shall utilize the Supports Intensity Scale® (SIS) to assess the needs of adult recipients who are on the DD waiver and for those who are newly allocated. The SIS assessment shall be administered at regular intervals, typically after at least three annual ISPs, to an eligible recipient who is **17 years of age or older and will be at least 18** years of age at the time of his or her ISP start date. The SIS quantifies the pattern and intensity of support needs of an eligible recipient with intellectual or developmental disabilities by obtaining information about the needs of each eligible recipient through a standardized assessment process.

B. Supplemental questions are reviewed by the SIS assessor with respondents at the end of each SIS assessment. The SIS assessor records responses provided and the information is included in the results issued. Responses are only applicable when there is extensive support needed (denoted by a "2") on any item in the exceptional medical support needs section of the SIS assessment or on specific items related to severe risk of injury to self or others in the exceptional behavioral support needs section of the SIS assessment. The supplemental questions are related to:

(1) severe medical risk;

(2) severe community safety risk - convicted;

(3) severe community safety risk - not convicted; and

(4) severe risk of injury to self.

C. The SIS assessment shall be scheduled prior to the eligible recipient's ISP start date so that the interdisciplinary team can receive the SIS results for use during the ISP and budget planning process. The interdisciplinary team should consider the results of the SIS and all other relevant data in order to create an ISP and proposed budget that is centered on the individual needs and desires of the participant. The interdisciplinary team is not restricted

to the service package suggested by the results of the SIS and NM DDW Group Assignment process, and the DD Waiver recipients should request and receive any DD Waiver service that is clinically justified. An eligible recipient shall be offered options for dates and times to schedule the SIS assessment at least four months prior to the ISP start date.

D. The SIS assessment scheduling process shall include planning for accommodations, education about choice of respondents, and the setting of the time and location.

E. The eligible recipient being assessed is strongly encouraged, but is not required, to be involved in the entire SIS assessment. However, the assessed eligible recipient must at least personally meet the SIS® assessor at the time of the assessment.

F. Not less than two primary qualified respondents, who are usually primary caregivers or direct support professionals in residential and day service programs, must attend the assessment. The eligible recipient being assessed can also be a primary qualified respondent. Primary qualified respondents are not required to have clinical expertise or professional degrees. To qualify as a primary respondent, an individual must have:

(1) known the eligible recipient for at least three months; and

(2) recently observed the eligible recipient in one or more settings and for at least several hours per setting; and

(3) the ability to describe the eligible recipient's support needs.

G. Guardians and close family members are strongly encouraged and welcomed to be involved in the eligible recipient's SIS assessment; however, they need not be qualified as a primary respondent.

H. The attendance of ancillary respondents is optional but encouraged when appropriate as requested by the individual and guardian, if applicable. An ancillary respondent is an individual who is typically a medical, behavioral or therapy professional who can provide clinical information that adds perspective particularly for individuals with complex support needs.

I. An eligible recipient may have an attorney present to observe the administration of the SIS assessment. Counsel for an eligible recipient will not participate in or interrupt the administration of the SIS assessment. The state of New Mexico, HSD, DOH, or the SIS assessor is under no obligation to pay any fees or costs associated with the attendance of an attorney at a SIS assessment; such legal fees and costs are solely the responsibility of the eligible recipient or his or her authorized representative.

J. Standard guidelines for administering the SIS assessment and supplemental questions require that:

(1) the SIS assessor has been trained and certified to provide SIS assessments;

(2) the SIS assessor provides information to the primary and ancillary respondents about the SIS® assessment process prior to starting the assessment;

(3) the SIS assessment is conducted face to face;

(4) the SIS assessor personally meets the eligible recipient at the time of the assessment;

(5) each question in the SIS assessment is explained to respondents prior to it being scored;

(6) each question is asked and discussed during the SIS assessment; this discussion shall include everyone who is present at the assessment and wishes to provide input;

(7) the final score of each question is shared with the respondents; and

(8) medical and behavioral needs are discussed with the respondents; and

(9) the SIS assessor be trained in standard administration of the supplemental questions and proper recording of the applicable responses.

K. An eligible recipient or his or her authorized representative may request a SIS reassessment during the eligible recipient's three year SIS assessment cycle:

(1) within 30 days from the date of the NM DDW Planning Packet Cover letter when the eligible recipient or his or her authorized representative believes there is a substantial departure from standard guidelines in the administration of his or her SIS assessment; or

(2) any time prior to the three year SIS assessment cycle when the eligible recipient has experienced a change in his or her condition that results in a significant change to the pattern and intensity of supports needed in one or more life areas.

L. A SIS reassessment, which requires the prior written approval of DOH, must be requested in accordance with the procedures and timelines established by DOH.

M. The DOH uses the SIS as a tool along with supplemental questions and a verification process to place eligible recipients in a New Mexico (NM) DDW group. Each NM DDW group describes individuals with a similar pattern of support needs. The services and supports provided in each NM DDW group are generally appropriate for individuals with similar service and support needs. The interdisciplinary team is not restricted to the service package suggested by the results of the SIS and NM DDW group assignment, and should request and receive any DD Waiver service that is clinically justified. The NM DDW groups A through G (table is located below) are assigned through the standardized application of decision rules associated with select SIS assessment scores, and when relevant, the supplemental question verification process. The decision rules are applied to any updated versions of the SIS assessment such as the SIS-A™ in a manner that is consistent with the application of the decision rules to the original SIS assessment in order to assure consistency and fairness across all individuals assessed.

(1) SIS sum ABE: Refers to the sum of the standards scores from supports intensity scale (SIS) support needs scale, part A: home living activities; part B: community living activities; and part E: health and safety activities.

(2) The medical support score refers to the total score in SIS assessment subsection titled: "medical support needed". The total score for this section when using any newer version of the SIS assessment is determined by a scoring protocol to match the original SIS assessment, i.e. additional items in the SIS®-A are treated as sub items of the original SIS item denoted "other".

(3) Behavioral support score refers to the total score in SIS assessment subsection titled: "behavioral support needed".

(4) Extraordinary medical risk is determined by verification of positive responses to supplemental questions through a document review by subject matter experts. The verification process is applicable when a respondent meets a

certain threshold in responses to supplemental questions which includes receiving extensive support needed (denoted by a "2") on any item within the exceptional medical support needs section of the SIS assessment. The verification process will not result in lower benefits than would have been assigned through the SIS assessment process.

(5) Dangerousness to others or extreme self-injury risk is determined by verification of responses to supplemental questions through a document review by subject matter experts. The verification process is applicable when a respondent meets a certain threshold in responses to supplemental questions which includes receiving extensive support needed (denoted by a "2") or on specific items related to severe risk of injury to self or others in the exceptional behavioral support needs section of the SIS assessment. The verification process will not result in lower benefits than would have been assigned through the SIS assessment process.

(6) The verification process will operate as currently conducted until the outside review process is fully operational and does not result in lower benefits than would have been assigned through the SIS assessment process. Once the outside review process is in place, the outside reviewer contractor will perform the functions currently performed in the verification process.

(7) Table identifying decision rules to define the NM DDW groups A through G:

NM DDW groups	SIS sum ABE	medical support score	behavioral support score
A: Mild support needs and low to moderate behavioral challenges	≥ 0 to ≤ 24	≥ 0 to ≤ 6	≥ 0 ≤ to 6
B: Low to moderate support needs and behavioral challenges	≥ 25 to ≤ 30	≥ 0 to ≤ 6	≥ 0 to ≤ 6
C: Mild to above average support needs and moderate to above average behavioral challenges	≥ 0 to ≤ 36	≥ 0 to ≤ 6	≥ 7 to ≤ 10
D: Above average support needs and low to moderate behavioral challenges	≥ 31 to ≤ 36	≥ 0 to ≤ 6	≥ 0 to ≤ 6
E: High support needs and mild to above average behavioral challenges	≥ 37 to ≤ 55	≥ 0 to ≤ 6	≥ 0 to ≤ 10
F: Extraordinary medical challenges	any	≥ 7 to ≤ 32 **OR** extraordinary medical risk	≥ 0 to ≤ 10
G. Extraordinary behavioral challenge	any	any	≥ 11 to ≤ 26 **OR** dangerousness to others or extreme self-injury risk

N. Information from the SIS assessment along with other information should be used for person-centered planning. When determining what service the eligible recipient needs, the IDT should consider the DDW group's suggested service packages and proposed budget with the understanding that the focus must always be on the individual's DD waiver support needs that can be clinically justified.

[8.314.5.13 NMAC - Rp, 8.314.5.13 NMAC, 3/1/2016]

8.314.5.14 DDW COVERED WAIVER SERVICES FOR IDENTIFIED POPULATION UNDER 18 YEARS OF AGE: The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized. DDW services must be provided in accordance with all requirements set forth by DDW service definitions, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance. The DDW covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an intermediate care facilities for individuals with intellectual disabilities (ICF-IID).

A. Eligible recipients age birth to 18: The child's level of care assessment is used to determine the annual resource allotment (ARA) within the under 18 years of age category. The service options funded within the ARA allow the family of an eligible

recipient, in conjunction with the IDT, the flexibility to choose any or all of these service options in an amount that does not exceed the eligible recipient's ARA. Services funded within the ARA include:

(1) behavioral support consultation;

(2) customized community support;

(3) respite;

(4) non-medical transportation;

(5) case management;

(6) supplemental dental care; and

(7) nutritional counseling.

B. Services from the under 18 years of age category must be coordinated with and shall not duplicate other services such as the medicaid school-based services program, the MAD early periodic screening diagnosis and treatment (EPSDT) program, services offered through the New Mexico public education department (PED), or the DOH family infant toddler program (FIT).

C. Service options available outside of the ARA include:

(1) environmental modifications;

(2) assistive technology;

(3) personal support technology; and

(4) socialization and sexuality education.

[8.314.5.14 NMAC - Rp, 8.314.5.14 NMAC, 3/1/2016]

8.314.5.15 DDW COVERED WAIVER SERVICES FOR IDENTIFIED POPULATION 18 YEARS OF AGE AND OLDER: The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized by DOH. DDW services must be provided in accordance with all requirements set forth by DOH DDW service definition, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance. DDW 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. There are seven NM DDW groups (designated A-G) each of which has a corresponding proposed service package. The proposed service package for each NM DDW group is based on assessed need and consists of a proposed base budget, a proposed professional services budget, and other services budget that make up the total funding authorized in the eligible recipient's ISP. The proposed service package and proposed budget for each of the seven NM DDW groups allows an eligible recipient 18 years of age and older and his or her IDT flexibility to request any covered service and service amount medically necessary to meet his or her needs through the outside reviewer when appropriate clinical criteria are met.

B. H Authorization allows an eligible adult recipient who has extenuating circumstances or extremely complex clinical needs, or both, to receive services beyond what is authorized in their current ISP/budget or to allow exceptions to DOH Standards related to the suggested service package option that corresponds with their NM DDW group assignment. Services outside of the suggested service package assigned to the corresponding NM DDW group may be authorized for an eligible recipient through the H authorization designation on a permanent basis as deemed appropriate by DOH, or on either a temporary or long-term basis. All eligible participants of the DDW program, regardless of their NM DDW group assignment, may apply for any type of DD Waiver service outside of their suggested service package.

(1) A permanent H authorization includes:

(a) an eligible recipient who is included in the class established in the matter of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990) is to receive a permanent NM DDW H authorization approval, regardless of his or her NM DDW group assignment. A Jackson class member may receive service types and amounts consistent with those approved in his or her ISP; and

(b) an eligible recipient assigned to NM DDW group A or B who was 55 years of age and older at the time of his or her annual ISP between March 1, 2013 and February 28, 2014 and who had been receiving DDW supported living services prior to March 1, 2013 are authorized to continue to use supported living services.

(2) The review process for temporary H authorization (up to 90 calendar days) requests for service is as follows:

(a) the interdisciplinary team (IDT) convenes and determines the need for consideration for a temporary H authorization request by identifying the specific need or service, and number of units necessary;

(b) the IDT is responsible for first completing any prior authorization processes and obtaining the maximum amounts of services suggested within the current NM DDW group assignment;

(c) the case manager submits a H authorization request for services to the regional office (RO);

(d) the RO director or designee makes a determination based on criteria from DOH whether the request meets the definition of extenuating circumstances or extremely complex clinical needs; once a determination on the review is made, the case manager or an eligible recipient, or his or her authorized representative will be notified of the decision in writing;

(e) if temporary H authorization request for services is approved by DOH, the case manager shall submit a budget revision with the DOH prior authorization to the DOH designee.

(3) The review process for long-term H authorization (greater than 90 calendar days) requests for service is as follows:

(a) the IDT convenes and determines the need for consideration for a long-term H authorization request by identifying the specific need or service and the number of units necessary;

(b) the IDT is responsible for first completing any prior authorization processes and obtaining the maximum amounts of services suggested within the current NM DDW group assignment;

(c) the case manager is responsible to submit a H authorization request for services to the RO based on information and consultation from the individual and guardian, if applicable;

(d) the RO director processes the request and sends the request to the RO bureau chief for review; the RO bureau chief makes a determination on the H authorization request by reviewing the following:

(i) the request meets at least one of the following: the definition of clinical need, extenuating circumstances, or extremely complex clinical needs;

(ii) the options within the eligible recipient's current NM DDW group assignment have been fully explored;

(iii) the individual has significant support needs that are not currently being met;

(iv) evidence of the previous and current ISP year utilization;

(v) medicaid state plan benefits have been exhausted;

(vi) that generic/natural resources to address the extenuating circumstance or complex need have been explored;

(vii) that the nature of the extenuating circumstance or complex need is anticipated to last longer than 90 calendar days, and

(viii) that the individual's need for a long-term H authorization request for services is not exclusively due to a significant change in condition or personal life circumstances that can otherwise be addressed through temporary H authorization request for services needed or pending the request for a SIS reassessment;

(e) DOH makes a determination based on its criteria set by DOH whether the request meets the definition of extenuating circumstances or extremely complex clinical needs; once a determination is made, the case manager and the eligible recipient and his or her authorized representative (if applicable) will be notified of the decision in writing;

(f) if the long-term H authorization request for services is approved by DOH, the case manager shall submit a budget revision with the approved prior authorizations to the DOH designee.

C. When determining what service the eligible recipient needs, the IDT should consider the DDW group's suggested service packages and proposed budget with the understanding that the focus must always be on the individual's DD waiver support needs that can be clinically justified. Services available:

(1) Case management services: Case management services assist an eligible recipient to access MAD covered services. A case manager also links the eligible recipient to needed medical, social, educational and other services, regardless of funding source. DDW 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 an eligible recipient 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 authorized representative, and the entire interdisciplinary team. The case manager is an advocate for the eligible recipient he or she serves, is responsible for developing the 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:

(a) assessing needs;

(b) facilitating eligibility determination for persons with developmental disabilities;

(c) directing the service planning process;

(d) advocating on behalf of the eligible recipient;

(e) coordinating service delivery;

(f) assuring services are delivered as described in the ISP; and

(g) maintaining a complete current central eligible recipient record (e.g. ISP, ISP budget, level of care documentation, assessments).

(i) Cost-effectiveness is a DDW requirement mandated by federal regulation. The fiscal responsibilities of the case manager include assuring cost containment by preventing the expense of DDW services from exceeding a maximum cost established by DOH and by exploring other options to address expressed needs.

(ii) 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.

(2) Respite services: Respite services are a flexible family support service for an eligible recipient. The primary purpose of respite services is to provide support to the eligible recipient and give the primary, unpaid caregiver relief and time away from his or her 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 or her own choices with regard to daily activities. Respite services will be scheduled as determined by the primary caregiver. An eligible recipient receiving living supports or customized in-home supports (when an eligible recipient is not living with a family member), may not access respite services. Respite services may be provided in the eligible recipient's own home, in a provider's home, or in a community setting of the eligible recipient family's choice. Respite services must be provided in accordance with 8.314.5.10 NMAC.

(3) Adult nursing services: Adult nursing services (ANS) are provided by a licensed RN or LPN under the supervision of a RN to an eligible adult recipient. Adult nursing services are intended to support the highest practicable level of health, functioning and independence for an eligible recipient. They include direct nursing services and activities related to the nursing oversight of unrelated direct support staff when assisting with health related needs in specific settings.

(a) ANS is available to individuals ages 21 and over who reside in family living; those who receive customized in home supports and those who do not receive any living supports. It is available to any eligible recipient who has health related needs that require at least one of the following: nursing training, delegation or oversight of direct support staff during participation in customized community supports (individual or small group) or community integrated employment even if living supports or CCS-group are also provided.

(b) ANS is available to individuals ages 18-20 who reside in family living and who are at aspiration risk and desire to have aspiration risk management services. It

is also available to individuals who have health related needs that require nursing training, delegation or the oversight of non-related direct support staff during substitute care; customized community supports (individual or small group); community integrated employment or customized in home supports.

(c) There are two categories of adult nursing services:

(i) assessment and consultation services which includes a comprehensive health assessment (including assessment for medication delivery needs and aspiration risk) and consultation regarding available or mandatory services which requires only budgeting; and

(ii) ongoing services, which requires prior authorization and are tied to the eligible recipient's specific health needs revealed in the comprehensive health assessment and prior authorization process.

(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. PT, OT and SLP are skilled therapies that are recommended by an eligible recipient's IDT members and a clinical assessment that demonstrates the need for therapy services. All three therapy disciplines: PT, OT, and SLP will be available to all DD waiver recipients if they and their IDT members determine the therapy disciplines are necessary. Therapy services for an eligible adult recipient require a prior authorization except for his or her initial assessment. A RLD licensed practitioner, as specified by applicable state laws and standards, provides the skilled therapy services. Therapy services for eligible adult recipients must comply with 8.314.5.10 NMAC. For an eligible recipient under 21 years of age, he or she accesses covered therapy services through the early and periodic screening, diagnostic and treatment program (EPSDT).

(a) **Physical therapy (PT):** PT is a skilled, RLD 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. A RLD 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. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC.

(b) **Occupational therapy (OT):** OT is a skilled, RLD licensed therapy service involving the use of everyday life activities (occupations) for the purpose of evaluation, treatment, and management of functional limitations. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC. 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. COTAs may perform occupational therapy procedures and related tasks pursuant to a therapy intervention plan written by the supervising OT as allowed by RLD licensure. OT 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 an eligible recipient's performance skills;

(iii) health and wellness promotion to the eligible recipient;

(iv) environmental access and assistive technology evaluation and treatment for use by the eligible recipient; and

(v) training/consultation to eligible recipient's family members and direct support personnel.

(c) **Speech-language pathology:** SLP 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. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC. Speech-language pathology services are also used when an eligible recipient requires the use of an augmentative communication device. For example, SLP 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 of the eligible recipient; 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 and 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 his or her 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 an eligible recipient is 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 social security insurance (SSI) or other personal accounts and cannot be paid through the DDW. Living Support services for eligible recipients must comply with 8.314.5.10 NMAC. Living supports consists of family living, supported living and intensive medical 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 support 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.

(i)

Home studies: The family living services provider agency shall complete all DOH 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 DOH.

(ii)

Family living services: Family living can be provided to no more than two eligible recipients with intellectual or developmental disabilities at a time. An exception may be granted by DOH if three eligible recipients are in the residence, but only two of the three are on the DDW and the arrangement is approved by DOH 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 for an eligible recipient to receive this service when living alone. Supported living services cannot be provided in conjunction with any other living supports service, respite, or nutritional counseling.

(c)

Intensive medical living services: An intensive medical living supports agency provides residential supports for an eligible recipient in a supported living environment 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 his or her ISP. An eligible recipient must meet criteria for intensive medical living supports according to DDW service definitions and DDW standards for this service and he or she requires nursing care, ongoing assessment, clinical oversight and health management that must be provided directly by a MAD recognized RN or LPN, see 8.314.5.10 NMAC.

(i)

These medical needs include: skilled nursing interventions; delivery of treatment; monitoring for change of condition; and adjustment of interventions and revision of services and plans based on assessed clinical needs.

(ii)

In addition to providing support to an eligible recipient with chronic health conditions, intensive 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 is 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 from DOH. In order to accommodate referrals for short-term stays, each approved intensive medical living supports 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.

(iii)

The intensive medical living supports 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 of the eligible recipient. Daily nursing visits are required; however, a RN or a LPN under a RN's supervision 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 RN or LPN, under the supervision of a RN must be available to staff during periods when a RN or a LPN under a RN's supervision is not present. Intensive medical living supports require supervision by a RN, and must comply with 8.314.5.10 NMAC.

(iv)

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 (IADL) including housework, meal preparation, medication assistance, medication administration, shopping, and money management.

(v) The intensive 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. The intensive medical living provider must arrange transportation for all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options.

(vi) Intensive medical living supports providers must comply with 8.314.5.10 NMAC.

(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; 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) Based on assessed needs, customized community supports services may include personal support, nursing oversight, medication assistance or 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 provide fiscal management for the payment of 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 8.314.5.10 NMAC.

(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. DDW funds (e.g., the provider agency's reimbursement) may not be used to pay the eligible recipient for work. Community integrated employment services must comply with 8.314.5.10 NMAC. 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:

(i) completing a market analysis of product/business viability;

(ii) creating a business plan including development of a business infrastructure to sustain the business over time, including marketing plans;

(iii) referring and coordinating with the division of vocational rehabilitation (DVR) for possible funds for business start-up;

(iv) assisting in obtaining required licenses necessary tax identifications, incorporation documents and completing any other business paperwork required by local and state codes;

(v) supporting the eligible recipient in developing and implementing a system of bookkeeping and records management;

(vi) providing effective job coaching and on-the-job training and skill development; and

(vii) arranging transportation or public transportation during self-employment services.

(b) **Individual community integrated employment:** Individual community integrated employment is job coaching and job development for an employed eligible recipient 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:

(i) 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

(ii) arrange transportation or public transportation during individual community integrated employment

services.

(c) **Group community integrated employment:** Group community integrated employment is when 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:

(i) participate with the IDT to develop a plan to assist an eligible recipient who desires to move from group employment to individual employment; and

(ii) 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 behavioral support plan development, IDT training and technical assistance, and monitoring of an eligible recipient's behavioral support services.

(b) Behavioral support consultation services must comply with 8.314.5.10 NMAC.

(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 comply with 8.314.5.10 NMAC.

(10) **Environmental modification services:** Environmental modifications services include the purchasing and installing of equipment or making physical adaptions to an eligible recipient's residence that are necessary to ensure the health, welfare and safety of the eligible recipient or enhance his or her access to the home environment and increase his or her 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;

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

(xiv) 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 an eligible recipient's 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 comply with 8.314.5.10 NMAC.

(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 comply with 8.314.5.10 NMAC.

(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 of the crisis.

(c) Crisis response 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 bureau of behavioral support (BBS). 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 the BBS in which case duration and intensity of the crisis intervention will be assessed weekly by BBS staff.

(12) Non-medical transportation: Non-medical transportation services assists the eligible recipient in accessing other waiver supports and non-waiver activities identified in his or her ISP. Non-medical transportation enables the eligible recipient to gain physical access to non-medical community services and resources promoting the eligible recipient opportunity and responsibility in carrying out his or her ISP activities. This service is to be considered only when transportation is not available through the 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 comply with 8.314.5.10 NMAC.

(13) Supplemental dental care: Supplemental DDW dental care services are provided for an eligible recipient that requires routine oral health care more frequently than the coverage provided under other MAP benefit plans. Supplemental dental care provides one oral examination and one cleaning once every ISP year to an eligible recipient for the purpose of preserving or maintaining oral health. The supplemental dental care service must comply with 8.314.5.10 NMAC.

(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 his or her 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 DOH on behalf of the eligible recipient.

(c) Assistive technology purchasing agent services must comply with 8.314.5.10 NMAC.

(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 his or her own with intermittent support that allows him 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.), and furnishings to establish safe and healthy living arrangements, such as a 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 comply with 8.314.5.10 NMAC.

(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 recipient to be independent in the community or in his or her 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 the eligible recipient who has 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 comply with 8.314.5.10 NMAC.

(17) 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 the eligible recipient with risk factors for sexually inappropriate or offending behavior, as defined in the DDW definitions and DDW standards. This service is part of a continuum of behavioral support services (including behavioral 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 PRSC are to:

(i) provide a structured screening of the eligible recipient's behaviors that may be sexually inappropriate;

(ii) develop and document recommendations of the eligible recipient in the form of a report or consultation notes;

(iii) develop and periodically review risk management plans for the eligible recipient, when recommended; and

(iv) provide consultation regarding the management and reduction of the eligible recipient's 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 behavioral services must comply with 8.314.5.10 NMAC.

(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 the eligible recipient's 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 comply with 8.314.5.10 NMAC.

(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 his or her own home or family home. Customized in-home supports includes a combination of instruction and personal support activities provided intermittently 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 of the eligible recipient, 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 comply with 8.314.5.10 NMAC.

[8.314.5.15 NMAC - Rp, 8.314.5.14 NMAC, 3/1/2016]

8.314.5.16 NON-COVERED SERVICES: Only those services listed in the DDW benefit package may be reimbursed through the DDW. Room, board and ancillary services are not covered DDW services. An eligible recipient may access, as medically necessary, all medicaid state plan benefits in addition to his and her DDW services. If the eligible recipient is an enrolled member of a HSD managed care organization (MCO), he or she may access, as medically necessary, the benefits listed in 8.308.9 NMAC.

[8.314.5.16 NMAC - Rp, 8.314.5.15 NMAC, 3/1/2016]

8.314.5.17 INDIVIDUALIZED SERVICE PLAN (ISP): An ISP must be developed by an IDT 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 eligible recipient. In developing an ISP, the IDT should consider the DDW Group's suggested services packages and proposed budget with the understanding that the focus must always be on the eligible recipient's support needs that can be clinically justified. The ISP is submitted to DOH or its designee for final approval. DOH or its designee must approve any changes to the ISP; see 7.26.5 NMAC.

A. The IDT must review the eligible recipient's treatment plan every 12 months or more often if indicated. DOH shall provide the eligible recipient, his or her case manager and, as applicable, his or her guardian(s) a DDW planning packet that contains each of the following:

(1) an informational instructions cover letter;

(2) notice of right to appeal pursuant to 8.314.5.21 NMAC;

(3) a copy of the my supports profile report created by DOH for that recipient;

(4) notice of the proposed DDW group assignment and suggested associated service package;

(5) notice of the proposed annual budget for the recipient;

(6) a copy of the DDW group assignment decision rules; and

(7) any additional information that MAD or DOH/DDSD may determine, from time to time, to be of assistance to the IDT in creating an ISP.

B. The IDT is responsible for compiling clinical documentation to justify the requested services and budget to the OR for adult recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990).

C. 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 of an eligible recipient;

(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 eligible recipient's ISP; 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.

D. Upon completion of the ISP by the IDT, the case manager shall develop a budget to be evaluated in accordance with the outside reviewer (OR) process; see Subsection D of 8.314.5.18 NMAC.

E. Upon completion of the ISP by the IDT, the case manager shall develop a budget to be evaluated in accordance with the medicaid third party assessor (TPA) review process for child recipients and class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990).

F. All services must be provided as specified in the ISP.

[8.314.5.17 NMAC - Rp, 8.314.5.16 NMAC, 3/1/2016]

8.314.5.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under the DDW, 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 8.310.2 NMAC. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. MAD prior authorization: To be eligible for DDW 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 eligible recipient's person centered ISP must specify the type, amount and duration of services and meet clinical criteria. 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. DOH prior authorization: Certain services are subject to utilization review by DOH.

C. 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 services, including 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.

D. Outside review process: All services for adult recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990) will be reviewed by an OR contracted by DOH. The OR will adhere to deadlines set forth in its contract with the DOH. The OR will apply the DDW clinical criteria to make a clinical determination on whether the requested services are needed, and will recommend whether the requested annual budget and ISP should be approved. If the OR approves in whole or part the requested ISP and budget, the OR will send the approved portion of the budget to the medicaid TPA for entry into the medicaid management information system and issue a prior authorization to the case manager. If there is a denial in part or whole, the OR decision must be in writing, identify a list of all documents and input considered by the OR team during its review, and state the reasons for any denial of requested services. The eligible recipient, case manager, and guardian (if applicable) will be provided with this written determination and notice of an opportunity to request a fair hearing as well as an agency review conference.

(1) The eligible recipient, case manager, and guardian (if applicable) may submit to the OR additional information relating to support needs.

(2) The decision of the OR approving services requested by the DDW participant is binding on the State. However, the state may agree to overturn a decision to deny services requested by the DDW participant at a requested agency conference.

E. 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.

[8.314.5.18 NMAC - Rp, 8.314.5.17 NMAC, 3/1/2016]

8.314.5.19 REIMBURSEMENT: DDW service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. A DDW provider must follow 8.302.2 NMAC, MAD billing instructions, utilization review instructions, and supplements. Reimbursement to providers of waiver services is made at a predetermined reimbursement rate.

[8.314.5.19 NMAC - Rp, 8.314.5.18 NMAC, 3/1/2016]

8.314.5.20 RIGHT TO A HSD ADMINISTRATIVE HEARING: An eligible recipient may request a HSD administrative hearing to appeal a decision of MAD or its third party assessor contractor, or the OR, that is an adverse action against the recipient. Prior to the fair hearing an eligible recipient has the right to an agency review conference. An agency review conference (AC) means an optional conference offered by the DOH to provide an opportunity to informally resolve a dispute over the denial, suspension, reduction, termination or modification of DDW benefits or services. An AC will be attended by the recipient and their authorized representative (if applicable) and by a representative of the DOH. The recipient may also bring whomever he or she wishes to assist during the AC. The AC is optional and shall in no way delay or replace the fair hearing process or affect the deadline for a fair hearing request.

A. An authorized representative means any individual designated by the eligible recipient or his or her guardian, if applicable, to represent the recipient and act on their behalf. The authorized representative must provide formal documentation authorizing him or her to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the recipient's guardian or attorney.

B. If a resolution is reached through the AC, DOH will issue written notification within seven business days of the AC to the recipient, recipient's guardian (if applicable) and case manager. The case manager will then prepare a budget for submission to the medicaid TPA based on that resolution.

C. Unless the fair hearing request is withdrawn by the recipient or recipient's guardian or lawyer, any requested fair hearing will proceed. At the fair hearing the claimant may raise any relevant issue and present any relevant information that he or she chooses. See 8.352.2 NMAC for a description of a claimant's HSD administrative hearing rights and responsibilities.

D. In addition to the requirements set forth in 8.352.2 NMAC, HSD and DOH shall take such actions as are necessary to assure the presence at the hearing of all necessary witnesses within DOH's control, including, when relevant to a denial of services or when requested by the claimant, the SIS assessor who conducted the assessment at issue, and a representative of the OR with knowledge of the claimant's case and the reason(s) for the denial, in whole or in part, of any requested services.

E. Denials of services through the H authorization process or other actions during this process adverse to the participant can also be appealed through a fair hearing.

F. All HSD administrative hearings are conducted in accordance with state and federal law.

G. No ex parte communications with an HSD administrative law judge are permitted by any DDW participant or counsel regarding any pending case. The MAD director shall not have ex parte communications regarding any pending cases with any DDW participant or counsel involved in that case. The MAD director's decision shall be limited to an on the record review.

[8.314.5.20 NMAC - Rp, 8.314.5.19 NMAC, 3/1/2016]

8.314.5.21 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HSD ADMINISTRATIVE HEARING PROCEEDING: A continuation of an existing DDW benefit or benefits is automatically provided to an eligible recipient claimant pending the resolution of the outside review process and any subsequent fair hearing. The continuation of a benefit is only available to a claimant that is currently receiving the appealed benefits. The continuation of the benefits will be the same as the claimant's current allocation, budget or LOC unless a revision is agreed to in writing by the eligible recipient (or authorized representative) and DOH.
[8.314.5.21 NMAC - Rp, 8.314.5.20 NMAC, 3/1/2016]

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, 3/19/1984.

History of Repealed Material:
ISD-Rule 310.2000, Coordinated Community In-Home Care Services, Repealed 1/18/1995.
8 NMAC 4.MAD.736.12 - Repealed 9/1/1998; and
8 NMAC 4.MAD.736.412 - Repealed 9/1/1998.
8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, Repealed 3/1/2007.
8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, filed 2/15/2007 - Repealed effective 11/1/2012.
8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, filed 10/2/2012 - Repealed effective 3/1/2016.

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, 3/1/2016]

8.314.6.2 SCOPE: The rule applies to the general public.
[8.314.6.2 NMAC - Rp, 8.314.6.2 NMAC, 3/1/2016]

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 Titles XI, XIX, and XXI of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978.
[8.314.6.3 NMAC - Rp, 8.314.6.3 NMAC, 3/1/2016]

8.314.6.4 DURATION: Permanent.
[8.314.6.4 NMAC - Rp, 8.314.6.4 NMAC, 3/1/2016]

8.314.6.5 EFFECTIVE DATE: March 1, 2016, unless a later date is cited at the end of a section.
[8.314.6.5 NMAC - Rp, 8.314.6.5 NMAC, 3/1/2016]

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 (MAP).
[8.314.6.6 NMAC - Rp, 8.314.6.6 NMAC, 3/1/2016]

8.314.6.7 DEFINITIONS:

A. 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 services and the cost of goods approved by the TPA. Once approved, this is the AAB.

B. Authorized representative: The individual designated to represent and act on the member's behalf. The eligible recipient or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the eligible recipient. The eligible recipient's authorized representative may be a service provider (depending on what the eligible recipient or court order allows) for the eligible recipient. An authorized representative cannot approve his or her own timesheet. The authorized representative cannot serve as the eligible recipient's consultant.

C. Category of eligibility (COE): To qualify for medical assistance program (MAP) services, an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible. An eligible recipient in the mi via program must belong to one of the MAP categories of eligibility (COE) described in 8.314.6.13 NMAC.

D. Centers for medicare and medicaid services (CMS): Federal agency within the United States department of health (DOH) and human services that works in partnership with New Mexico to administer medicaid and MAP services under HSD.

E. Consultant provider: An agency or an individual that provides consultant and support guide services to the eligible recipient that assist the eligible recipient (or the eligible recipient's family, personal representative or the authorized 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.

F. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria who is approved to receive MAD services through the mi via program.

G. 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 is required to have an EOR when he or she utilizes employees for mi via services. An eligible recipient may be his or her own EOR unless the eligible recipient is a minor, or has an authorized

representative 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.

H. Financial management agency (FMA): Contractor that helps implement the AAB by paying the eligible recipient's service providers and tracking expenses.

I. Home and community-based services (HCBS) waiver: A set of MAD services that provides alternatives to long-term care services in institutional settings, such as the mi via waiver program. CMS waives certain statutory requirements of the Social Security Act to allow HSD to provide an array of community-based options through these waiver programs.

J. Individual budgetary allotment (IBA): The maximum budget allotment available to an eligible recipient, determined by his or her age established level of care (LOC). Based on this maximum amount, the eligible recipient will develop a plan to meet his or her assessed functional, medical and habilitative needs to enable the eligible recipient to remain in his or her community.

K. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): Facilities that are licensed and certified by the New Mexico DOH to provide room and board, continuous active treatment and other services for eligible recipients with a primary diagnosis of intellectually disabled.

L. Legally responsible individual (LRI): A 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, or a guardian who must provide care to an eligible recipient under 18 years of age or the spouse of an eligible recipient.

M. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the mi via program.

N. 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.

O. Personal representative: The eligible recipient may select an individual to act as his or her personal representative for the purpose of offering support and assisting the eligible recipient understand his or her mi via services. The eligible recipient does not need a legal relationship with his or her personal representative. The personal representative will not have the authority to direct the member's mi via waiver services or make decisions on behalf of the eligible recipient. Directing services remains the sole responsibility of the eligible recipient or his or her authorized representative. The personal representative cannot serve as the eligible recipient's consultant and cannot approve his or her specific timesheet.

P. Reconsideration: An eligible recipient who disagrees with a clinical or medical utilization review decision or action may submit a written request to the third-party assessor for reconsideration of its decision. The eligible recipient or his or her authorized representative may submit the request for a reconsideration through the consultant or the consultant agency or may submit the request directly to MAD.

Q. Self-direction: The process applied to the service delivery system wherein the eligible recipient identifies, accesses and manages the services (among the MAD approved mi via 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.

R. Service and support plan (SSP): A plan that includes mi via services that meet the eligible recipient's needs that include: the projected amount, the frequency and the duration of the services; the type of provider who will furnish each service; other services the eligible recipient will access; and the eligible recipient's available supports that will compliment mi via services in meeting his or her needs.

S. 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 or vendor functions or with other aspects of implementing his or her SSP.

T. Third-party assessor (TPA): The MAD 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 mi via services.

U. Waiver: A program in which the CMS has waived certain statutory requirements of the Social Security Act to allow states to provide an array of HCBS 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, 3/1/2016]

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, 3/1/2016]

8.314.6.9 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER:

A. New Mexico's medicaid 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 developmental disabilities (DD), or medically fragile (MF) conditions. (See 42 CFR 441.300.)

B. The mi via program is for an eligible recipient who meets the LOC otherwise provided in an ICF/IID.

(1) DOH, at the direction of MAD, is responsible for the daily administration of the mi via program.

(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, 3/1/2016]

8.314.6.10 MI VIA CONTRACTED ENTITIES AND PROVIDERS SUPPORTING SELF-DIRECTED SERVICES: Services are to be provided in the least restrictive manner. HSD does not allow for the use of any restraints, restrictive interventions, or seclusions to an eligible mi via recipient. 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 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 a LOC assessment, assigning the applicable IBA, approving the SSP and authorizing an eligible recipient's annual budget in accordance with 8.314.6 NMAC and the mi via service standards. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.6.13 NMAC; determinations are done initially for an eligible recipient who is newly enrolled in the mi via program 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 or her home, a location agreed upon by the participant and TPA and approved by HSD, 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 medical condition or LOC has changed;

(2) applies the information from the LOC documentation and the following assessments: long-term care assessment abstract (ICF/IID), the comprehensive individual assessment (CIA), or other MAD approved assessment tools, as appropriate for the COE, to assign the IBA for the eligible recipient that is 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 8.314.6 NMAC and mi via 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 there is eligible recipient and program compliance with state and federal employment requirements, monitors, and makes available to the eligible recipient the 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 recipient is 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 8.314.6 NMAC and mi via 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 recipient 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 or her consultant, and quarterly and annual documentation of expenditures to MAD;

(6) receive and verify employee and vendor 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 recipient and solve problems related to the FMA's responsibilities; and

(9) report to the consultant provider, MAD and DOH any concerns related to the health and safety of an eligible recipient or if the eligible recipient is not following the approved SSP and AAB.

[8.314.6.10 NMAC - Rp, 8.314.6.10 NMAC, 3/1/2016]

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 or direct support worker, a provider agency, (excluding consultant providers which are covered in a different subsection) or a vendor, including those that provide professional services, each individual or entity must meet the general and service specific qualifications set forth in this rule initially and continually meet licensure requirements as applicable, and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. The provider agency is responsible to ensure that all agency employees meet the required qualifications. In order to be an authorized provider for the mi via program and receive payment for delivered services, the provider must complete and sign an employee or vendor provider agreement and all required tax documents. Individual employees may not provide more than 40 hours of services in a consecutive seven-day work week. The provider must have credentials verified by the eligible recipient or the EOR and the FMA.

(1) Prior to rendering services to an eligible mi via recipient as an independent contractor for homemaker or direct support worker, respite, community direct support, employment supports, and in-home living support provider, an individual seeking to provide these services must:

(a) obtain an internal revenue service (IRS)-SS8 letter determining the worker's status as an independent contractor or as an employee; and

(b) provide to the FMA and consultant agency the IRS SS-8 letter; if the IRS SS-8 letter either determines or informs the worker that he or she meets the status of an independent contractor, the consultant agency must submit the SSP changes to the TPA; once the SSP is approved the independent contractor may begin the enrollment process with the FMA.

(2) An authorized consultant provider must have a MAD approved provider participation agreement (PPA) and the appropriate approved DOH developmental disabilities division (DDSD) agreement.

B. General qualifications:

(1) Individual employees, independent providers,

including non-licensed homemaker/direct support workers 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) prior to the initial hire and every three years after initial hire pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 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 or her authorized 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 its service standards.

(2) Vendors, including those providing professional services shall meet the following qualifications:

(a) shall be qualified to provide the service;

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

(c) meet financial solvency, maintain and adhere to training requirements, record management, quality assurance policy and procedures, if applicable;

(d) be in good standing with and comply with his or her New Mexico practice board or other certification or licensing required to render mi via services in New Mexico; and

(e) must not have a DOH current adverse action against them.

(f) assure that employees of the vendor:

(i) are at least 18 years of age;

(ii) are qualified to perform the service and demonstrate capacity to perform required tasks;

(iii) are able to communicate successfully with the eligible recipient;

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

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

(vi) complete training specific to the eligible recipient's needs; an assessment of training needs is determined by the eligible recipient or his or her authorized 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 its service standards.

(3) Qualified and approved relatives, authorized representatives or personal representatives may be hired as employees and paid for the provision of mi via services (except consultant and support guides, customized community group supports services and related goods). The services must be identified in the eligible recipient's approved SSP and AAB, and the EOR is responsible for verifying that services have been rendered by completing, signing, and submitting documentation, including the timesheet, to the FMA. These services must be provided within the limits of the approved SSP and AAB and may not be paid in excess of 40 hours in a consecutive seven-day work week. LRIs, authorized representatives, personal representatives or relatives may not be both a paid employee for the eligible recipient and serve as the eligible recipient's EOR. An authorized or personal representative who is also an employee may not approve his or her own timesheet.

(4) A LRI may be hired and paid for provision of mi via services (except transportation services when requested for a minor, a consultant and support guide, and customized community group supports services, and related goods) under extraordinary circumstances (i) in order to assure the health and welfare of the eligible recipient and (ii) to avoid institutionalization when approved by DOH. MAD must be able to receive federal financial participation (FFP) for the services.

(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 mi via 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) A LRI who is a service provider must comply with the following:

(i) a parent, parents in combination, legal guardian of a minor, or a spouse of the eligible recipient, may not provide more than 40 hours of services in a consecutive seven-day work week; for parents or legal guardians of the eligible recipient, 40 hours is the total amount of service regardless of the number of eligible recipients under the age of 21 who receive services through the mi via program;

(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 DOH when a provider is chosen who is:

(i) a parent or legal guardian of an eligible recipient who is a minor; or

(ii) the eligible recipient's spouse.

(f) 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 EOR's or authorized representatives are responsible for ensuring that providers, vendors and contractors have received these materials and for updating them as new materials are received from MAD and DOH. MAD makes available on its website, and in hard copy format, information necessary to participate in medical assistance programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. DOH makes available on its website information, instructions and guidance on its administrative requirements for the mi via program. When enrolled, an eligible recipient or his or her authorized representative, or the provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or authorized representative, or the 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 authorized representative, or the 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 employee of any type may be paid in excess of 40 hours within the established consecutive seven day 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 such as offering an eligible recipient or his or her authorized representative gratuities in the form of entertainment, gifts, financial compensation to alter that eligible recipient's selection of provider agencies, service agreements, medication, supplies, goods or services.

(d) Those signing a payment request form for vendor services rendered to an eligible recipient may not serve as an employee, contractor or subcontractor of that vendor for that eligible recipient. An eligible recipient who does not have an authorized representative providing oversight of the eligible recipient's financial matters may sign off on the payment request form.

(6) The EOR is the individual responsible for directing the work of the eligible recipient's employees. An eligible recipient is required to have an EOR when utilizing employees. The EOR may be the eligible recipient or a designated qualified individual. When utilizing both vendors and employees, an EOR is required for oversight of employees and to sign payment request forms for vendors. The EOR must be documented with the FMA, whether the EOR is the eligible recipient or a designated qualified individual.

(a) An eligible recipient that has an authorized representative over the eligible recipient's financial matters may not be his or her own EOR nor sign payment vendor request forms for vendors.

(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. Any out of state EOR residing beyond this radius who has been approved prior to the effective date of this rule may continue to serve as the EOR.

(d) The eligible recipient's provider may not also be his or her EOR.

(e) An EOR whose performance compromises the health, safety or welfare of the eligible recipient, may have his or 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, or subcontractor 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.

(g) An EOR is not required if an eligible recipient is utilizing only vendors for services; however, an EOR can be identified by an eligible recipient to assist with the use of vendors. In some instances an EOR for vendor services may be required by MAD. Those signing a payment request form for vendor services rendered to an eligible recipient may not serve as an employee, contractor or subcontractor of that vendor for that eligible recipient. An eligible recipient who does not have an authorized representative providing oversight of the eligible recipient's financial matters may sign off on the payment request form.

C. Service specific qualifications for consultant services providers: In addition to general requirements, a consultant provider shall ensure that all individuals hired or contracted to provide consultant services meet the criteria specified in this section and comply with all applicable NMAC MAD rules and mi via 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 people living with disabilities; or

(b) have a minimum of six years of direct experience related to the delivery of social services to people living with disabilities; and

(c) be employed by an enrolled mi via consultant provider agency; and

(d) complete all required mi via program

orientation and training courses; and

(e) be at least 21 years of age.

(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 rule;

(b) have experience working with 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; and

(g) be at least 18 years of age.

D. Service specific qualifications for personal plan facilitation providers: In addition to general MAD 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 mentored 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 MAD 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: Provider agencies must be homemaker agencies certified by the MAD or its designee or a home health agency holding a New Mexico home health agency license. A homemaker and home health agency 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 or 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 (RN) 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 in-home living supports providers: Provider agencies must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. In-home living agency staff and its direct staff rendering the service must have one year of experience working with people with disabilities.

F. Service specific qualifications for community membership support providers: In addition to general MAD requirements, the following types of providers must meet additional qualifications specific to the type of services provided. An agency providing community membership 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) A job developer, whether an agency or individual provider, must:

(i) be at least 21 years of age;

(ii) pass criminal background check and abuse registry screen;

(iii) have experience developing and using job and task analyses;

(iv) have experience 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, local businesses, retired executives, DDSD resources, and have substantial knowledge of the Americans with Disabilities Act (ADA); and

(v) complete training on critical incident, abuse, neglect, and exploitation.

(b) Job coaches whether an agency or individual provider, must:

(i) be at least 18 years of age;

(ii) have a high school diploma or GED;

(iii) pass criminal background check and abuse registry screen;

(iv) be qualified to perform the service;

(v) have experience with providing employment supports and training methods;

(vi) be knowledgeable about business and employment resources;

(vii) have the ability to successfully communicate with the employer and with the eligible recipient and his or her coworkers to develop and encourage natural supports on the job; and

(viii) complete training on critical incident, abuse, neglect, and exploitation.

(2) Qualifications of customized community group supports providers: Agencies providing community group support services must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Providers, whether an agency staff or

an individual provider must meet the following qualifications:

(i) must be at least 18 years of age;

(ii) pass criminal background check and abuse registry screen;

(iii) demonstrate capacity to perform required tasks;

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

(v) have the ability to successfully communicate with the eligible recipient.

G. Service specific qualifications for providers of health and wellness supports: In addition to the general MAD 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, physical therapy assistants and occupational therapy assistants must possess a therapy license in their respective field from the New Mexico regulation and licensing department (RLD). Speech clinical fellows must possess a clinical fellow license from the New Mexico RLD.

(2) **Qualifications of behavior support consultation providers:** Behavior support consultation provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior support consultation provider agencies shall comply with all applicable federal, state, and rules and procedures regarding behavior consultation. Providers of behavior support consultation services must possess qualifications in at least one of the following areas:

(a) a licensed psychiatrist by his or her New Mexico practice board;

(b) a regulation and licensing department (RLD) licensed clinical psychologist;

(c) a RLD licensed psychologist associate, (masters or Ph.D. level);

(d) a RLD licensed independent social worker (LISW);

(e) a RLD licensed master social worker (LMSW);

(f) a RLD licensed professional clinical counselor (LPCC);

(g) a licensed clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) who is certified in psychiatric nursing by a national nursing organization who can furnish services to adults or children as his or her certification permits;

(h) a RLD licensed marriage and family therapist (LMFT); or

(i) a RLD licensed practicing art therapist (LPAT) by RLD.

(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 and licensed by the RLD, (Nutrition and Dietetics Practice Act Section 61-7A-7 et seq. NMSA 1978).

(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, (Sections 61-3-14 and 61-3-18 NMSA 1978).

(5) **Qualifications of specialized therapy providers:** For each type of specialized therapy providers, the provider must hold the appropriate New Mexico licensure or certification for the services he or she renders to an eligible recipient:

(a) a RLD license in acupuncture and oriental medicine;

(b) a license or certification with the appropriate specialized training and clinical experience and supervision whose scope of practice includes biofeedback;

(c) a RLD license in chiropractic medicine;

(d) a license or certification for which he or she has appropriate specialized training and clinical experience and whose scope of practice includes cognitive rehabilitation therapy;

(e) a RLD license in a physical therapy, or occupational therapy, or speech therapy and whose scope of practice includes hippotherapy with the appropriate specialized training and experience;

(f) a RLD license in massage therapy;

(g) a RLD license in naprapathic medicine;

(h) a master's or a higher level behavioral health degree with specialized play therapy training, clinical experience and supervision and whose RLD license's scope of practice includes play therapy; and

(i) a native American healer who is recognized as a traditional healer within his or her community.

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

(1) **Qualifications of transportation providers:**

(a) Individual transportation providers must:

(i) possess a valid New Mexico driver's license with the appropriate classification;

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

(iii) have a current insurance policy and vehicle registration.

(b) Transportation vendors must hold a current business license and tax identification number. Each agency will ensure any vehicle used to transport an eligible recipient is equipped with an up-to-date first aid kit. Each agency will ensure transportation drivers meet the following qualifications:

(i) holds a valid New Mexico driver's license of the appropriate classification to transport an eligible recipient;

(ii) holds a current vehicle insurance policy meeting New Mexico's insurance mandates in place for the vehicle used to transport an eligible recipient; and

(iii) holds a New Mexico vehicle registration for the vehicle used to transport an eligible recipient.

(2) **Qualifications of emergency response providers:** Emergency response providers must comply with all laws, rules and regulations of the state of New

Mexico.

(3) **Qualifications of respite providers:** Respite services may be provided by eligible individual respite providers; RN or practical nurses (LPN); or respite provider agencies. Individual RN or LPN providers must be licensed by the New Mexico 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 and tax identification for New Mexico and the federal government.

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

[8.314.6.11 NMAC - Rp, 8.314.6.11 NMAC, 3/1/2016]

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 NMAC MAD 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, as detailed in applicable NMAC MAD provider rules 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 PPA requirements and NMAC MAD rules and requirements, including but not limited to 8.310.2 NMAC and 8.321.2 NMAC and 8.302.1 NMAC.

[8.314.6.12 NMAC - Rp, 8.314.6.12 NMAC, 3/1/2016]

8.314.6.13 ELIGIBILITY REQUIREMENTS FOR RECIPIENT ENROLLMENT IN MI VIA: Enrollment in the mi via program is contingent upon the applicant meeting the eligibility requirements as described in this rule, 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 are available, DOH will offer the opportunity to eligible recipients to select mi via. Once an allocation has been offered to the applicant, he or she must meet certain medical and financial criteria in order to qualify for mi via enrollment located in 8.290.400 NMAC. The eligible recipient must meet the LOC required for admittance to an ICF-IID. After initial eligibility has been established for a recipient, on-going eligibility must be determined on an annual basis.

[8.314.6.13 NMAC - Rp, 8.314.6.13 NMAC, 3/1/2016]

8.314.6.14 ELIGIBLE RECIPIENT AND EOR RESPONSIBILITIES: Mi via eligible recipients have certain responsibilities to participate in the program. 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 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, or in a location approved by the state and seek assistance with the application and the recertification process as needed from a mi via consultant.

B. To participate in the mi via program, the eligible recipient must:

(1) comply with applicable NMAC rules to include this rule, mi via service standards and requirements 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 applicable NMAC rules to include this rule and service standards;

(4) use mi via program 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 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;

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

(14) have monthly contact and meet face-to-face quarterly with the consultant; and

(15) have an EOR if utilizing employees for services; the eligible recipient may be his or her own EOR unless the eligible recipient is a minor, or he or she has an authorized representative designated over financial matters; 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.

C. Additional responsibilities of the eligible recipient or EOR are detailed below:

(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 for at least six years from first date of service and ongoing.

D. Voluntary termination: An eligible recipient has a choice of receiving services through the non-self-directed waiver or through the mi via HCBS waiver. If the eligible recipient wishes to change to the non-self-directed HCBS waiver, a waiver change must occur in accordance with the mi via NMAC rule and mi via service standards. Transitions can only occur at the first of a month.

E. Involuntary termination: A mi via eligible recipient may be terminated involuntarily by MAD and DOH and offered services through a non-self-directed waiver or the medicaid state plan under the following circumstances.

(1) The eligible recipient refuses to comply with this rule and mi via service standards 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 or 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 mi via program. Examples include but are not limited to the following.

(a) The eligible recipient refuses to include and maintain services in his or her SSP and AAB that would address health and safety issues identified in his or 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 contractor's recommendations into his or her SSP and AAB.

(c) The eligible recipient exhibits behaviors which endanger himself or 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) When DOH is notified the eligible recipient continues to utilize either an employee or a vendor, or both who have consistently been substantiated against for abuse, neglect, exploitation while providing mi via services after notification of this on multiple occasions by DOH.

(6) The eligible recipient who is involuntarily terminated from the mi via program will be offered a non self-directed waiver alternative. If transfer to another waiver is authorized and accepted by the eligible recipient, he or 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 case manager 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, 3/1/2016]

8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA: The services covered by the mi via program 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's qualifying condition. The mi via program is the payor of last resort. The coverage of mi via services must be in accordance with 8.314.6 NMAC and mi via service standards. Waiver participants in all living arrangements are assessed individually and service plan development is individualized. The TPA will assess the service plans of participants living in the same residence to determine whether or not there are services that are common to more than one participant living in the same household in order to determine whether one or more employees may be needed to ensure that individual different cognitive, clinical, and habilitative needs are met.

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 and enrollment services: Consultant pre-eligibility and enrollment services are intended to provide information, support, guidance, and assistance to an individual 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 program services is offered to an individual, he or 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 offers pre-eligibility and enrollment services as well as on-going consultant services. Once the individual is determined to be eligible for mi via services, the consultant service provider will continue to render 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 or 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 or 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 their mi via services.

(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 face-to-face with the eligible recipient at least quarterly; one visit must be conducted in the eligible recipient's home at least annually. During monthly contact the consultant:

(a) reviews the eligible recipient's access to services and whether they were furnished per the SSP;

(b) reviews the eligible recipient's exercise of free choice of provider;

(c) reviews whether services are meeting the eligible recipient's needs;

(d) reviews whether the eligible recipient is receiving access to non-waiver services per the SSP;

(e) reviews activities conducted by the support guide, if utilized;

(f) documents changes in status;

(g) monitors the use and effectiveness of the emergency back-up plan;

(h) documents and provides follow up, if necessary, if challenging events occur that prevent the implementation of the SSP;

(i) assesses for suspected abuse, neglect, or exploitation and report accordingly; if not reported, takes remedial action to ensure correct reporting;

(j) documents progress of any time sensitive activities outlined in the SSP;

(k) determines if health and safety issues are being addressed appropriately; and

(l) discusses budget utilization concerns.

(2) 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 emergency backup plan;

(c) review SSP and 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 sections of the 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, including but not limited to complaints, eligibility issues, and health and safety issues, raised by the eligible recipient, authorized representative or personal representative.

(3) 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.

(4) Critical incident management responsibilities and reporting requirements: The consultant provider shall report incidents of abuse, neglect, exploitation, suspicious injury, environmental hazards, and eligible recipient death as directed by the appropriate state agency(ies). The consultant provider shall provide training to eligible recipients EOR, authorized representatives or other designated individuals regarding recognizing and reporting critical incidents. Critical incidents include abuse, neglect, exploitation, suspicious injury, environmental hazards and eligible recipient deaths. 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 eligible recipient to help ensure health and safety when a critical incident has occurred. Critical incident reporting requirements for mi via eligible recipients who have been designated with an ICF/IID LOC, critical incidents should be directed in the following manner.

(a) DOH triages, and investigates all reports of alleged abuse, neglect, exploitation, suspicious injury, environmental hazards, and eligible recipient deaths for mi via services and eligible recipients to include expected and unexpected deaths. The reporting of these critical incidents is mandated for all those providing mi via services pursuant to 7.1.14 NMAC. Any critical incidents must be reported to the children, youth and families department (CYFD) child protective services (CPS) or the DOH division of health improvement (DHI) incident management bureau (IMB) for eligible recipients under 18 years. For eligible recipient's 18 years and older, IMB is contacted to report any critical incidents. The reporter must then fax DHI the abuse, neglect and exploitation or report of death form within 24 hours of a verbal report. If the reporter has internet access, the report form shall be submitted via DHI's website. 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.

(b) With respect to mi via services provided

by any employee, contractor, vendor or other community-based waiver service agency having a provider agreement with DOH, any suspected abuse, neglect, exploitation, suspicious injury, environmental hazard, eligible recipient death must be reported to the CYFD/CPS or DOH/DHI/IMB for the eligible recipient under 18 years or to IMB for eligible recipients age 18 years or older. See Sections 27-7-14 through 27-7-31 NMSA 1978 (Adult Protective Services Act) and in Sections 32A-4-1 through 32A-4-34 NMSA 1978 (Child Abuse and Neglect Act).

(5) Conflict of interest: An eligible recipient's consultant may not serve as the eligible recipient's EOR, authorized representative or personal representative for whom he or she is the consultant. A consultant may not be paid for any other services utilized by the eligible recipient for whom he or she is the consultant, whether as an employee of the eligible recipient, a vendor, an employee or subcontractor of an agency. A consultant may not provide any other paid mi via services to an eligible recipient unless the recipient is receiving consultant services from another agency. The consultant agency may not provide any other direct services for an eligible recipient that has an approved SSP, an approved budget, and is actively receiving services in the mi via program. The consultant agency may not employ as a consultant any immediate family member or guardian for an eligible recipient of the mi via program that is served by the consultant agency. A consultant agency may not provide guardianship services to an eligible recipient receiving consultant services from that same agency. The consultant agency may not provide any direct support services through any other type of 1915 (c) Home and Community Based Waiver Program.

D. Personal plan facilitation: Personal plan facilitation supports planning activities that may be used by the eligible recipient to develop his or 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 or her family (or authorized representative, or personal 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, his or her authorized representative, or personal representative, 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 eligible recipient 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 timelines.

(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 an eligible recipient 21 years and older with activities of daily living, performance of general household tasks, and enable the eligible recipient to accomplish tasks he or she would normally do for himself or herself if he or she did not have a disability. Homemaker direct support services are provided in the eligible recipient's own 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 for him or herself, the eligible recipient arranges for the needed training. Services are not intended to replace supports available from a primary caregiver. Personal care services are covered under the medicaid state plan as enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for mi via eligible recipients under 21 years of age and are not to be included in an eligible recipient's AAB.

(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 in the eligible recipient's own home and outside the eligible recipient's home. The medicaid state plan home health aide services are intermittent and are 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. Home health aides are supervised by a RN. Supervision must occur at least once every 60 calendar days in the eligible recipient's home and be in accordance with the New Mexico Nurse Practice Act, Section 61-3-4 et seq. NMSA 1978.

(3) In-home living supports: In-home living supports are related to the eligible recipient's qualifying condition or disability and enable him or her to live in his or her apartment or house. Services must be provided in the home or apartment owned or leased by the eligible recipient or in the eligible recipient's home, not to include homes or apartments owned by agency providers. Service coordination and nursing services are not included in this service.

(a) These services and supports are provided in the eligible recipient's own home and are individually designed to instruct or enhance home living skills as well as

address health and safety.

(b) 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 and may be up to 24 hours per day as specified in the eligible recipient's SSP.

(c) Eligible recipients receiving in-home living supports may not use homemaker and direct support home health aide services or respite because they duplicate 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. This service does not include formal educational (including home schooling and tutoring related activities), or vocational services related to traditional academic subjects or vocational training.

(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 or her residence;

(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: The objective of employment supports services is to provide assistance that will result in community employment jobs for an eligible recipient which increases economic independence, self-reliance, social connections and the ability to grow within his or her career. Employment supports services are geared to place and support an eligible recipient with disabilities in competitive, integrated employment settings with non-disabled co-workers within the general workforce; or assist the eligible recipient in business ownership. Employment supports include job development and job coaching supports after available vocational rehabilitation supports have been exhausted, including programs funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) to an eligible recipient. Employment Services are to be individualized to meet the needs of the participant and not the needs of a group.

(a) Job development is a service provided to an eligible recipient by a skilled individual. The service has several components:

(i) conducting situational and or vocational assessments;

(ii) developing and identifying community based job opportunities that are in line with the eligible recipient's skills and interests;

(iii) supporting the eligible recipient in gainful skills or knowledge to advocate for his or herself in the workplace;

(iv) promoting career exploration for the eligible recipient based on interests within various careers through job sampling, job trials or other assessments as needed;

(v) arranging for or providing benefits counseling;

(vi) facilitating job accommodations and use of assistive technology such as communication devices for the eligible recipient's use;

(vii) providing job site analysis (matching workplace needs with those of the eligible recipient); and

(viii) assisting the eligible recipient in gaining or increasing job seeking skills (interview skills, resume writing, work ethics, etc.).

(b) The job coach provides the following services:

(i) training the eligible recipient to perform specific work tasks on the job;

(ii) vocational skill development to the eligible recipient;

(iii) employer consultation specific to the eligible recipient;

(iv) eligible recipient co-worker training;

(v) job site analysis for an eligible recipient;

(vi) education of the eligible recipient and co-workers on rights and responsibilities;

(vii) assistance with or utilization of community resources to develop a business plan if the eligible recipient elects to start his or her own business;

(viii) conduct market analysis and establish the infrastructure to support a business specific for the eligible recipient; and

(ix) increasing the eligible recipient's capacity to engage in meaningful and productive interpersonal interactions co-workers, supervisors and customers.

(c) Employment supports will be provided by staff at current or potential work sites. When employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by the eligible recipient receiving mi via services as a result of his or her disabilities but does not include payment for the supervisory activities rendered as a normal part of

the business setting. Federal financial participation (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 the eligible recipient's supported employment program; and

(iv) FFP cannot be claimed to defray expenses associated with an eligible recipient's start-up or operation of his or her business.

(3) Customized community group supports: Customized community group supports can include participation in congregate community day programs and community 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 group supports may include adult day habilitation programs, and other day support models. Customized community group supports are provided in integrated community settings such as day programs and community centers which can take place in non-institutional and non-residential settings. These services are available at least four or more hours per day one or more days per week. Service hours and days are specified in the eligible recipient's SSP.

G. Health and wellness:

(1) Extended skilled therapy for eligible recipients 21 years and older: Extended skilled therapy for adults may include physical therapy, occupational therapy or speech language therapy when skilled therapy services under the medicaid state plan are exhausted or are not a covered benefit. Eligible recipients 21 years and older in the mi via program access therapy services under the state medicaid 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 and older in the mi via program 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

(iv) identify, implement, and train on therapeutic strategies to support the eligible recipient and his or 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 the eligible recipient 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 or 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 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) provide consultation on usage and training for augmentative communication devices;

(iv) identify, implement and train therapeutic strategies to support the eligible recipient and his or 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, positive behavior support plan that is part of the eligible recipient's 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 or 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 support plans;

(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 or her service and support providers in order for services to be provided in the least restrictive manner; HSD does not allow the use of any restraints, restrictive interventions, or seclusion to an eligible recipient.

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

(b) **Biofeedback:** Biofeedback uses visual, auditory or other monitors to provide eligible recipients with 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 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 an eligible recipient's 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 an eligible recipient 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. An eligible recipient 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. Hippotherapy must be performed by a RLD licensed physical therapist, occupational therapist, or speech therapist.

(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 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 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 or 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. Transportation services for minors are not a covered service as these are services that a LRI would ordinarily provide for household members of the same age who do not have a disability or chronic illness.

(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 or her duties. If there is a paid primary caregiver residing with the eligible recipient providing living supports or community membership supports, or both, respite services cannot be utilized. 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 or 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. Respite cannot be used for purposes of day-care nor can it be provided to school age children during school (including home school) hours.

(4) Related goods: Related goods are equipment, supplies or fees and memberships, not otherwise provided through mi via, the medicaid state plan, or medicare. Related goods must directly relate to the member's qualifying condition or disability. Related goods must explicitly address a clinical, functional, medical, or habilitative need:

(a)

Related goods must address a need identified in the eligible recipient's SSP and meet the following requirements:

(i)

supports the eligible recipient to remain in the community and reduces the risk for institutionalization; and

(ii)

promote personal safety and health; and afford the eligible recipient an accommodation for greater independence; and

(iii)

decrease the need for other medicaid services; and

(iv)

accommodate the eligible recipient in managing his or her household; or

(v)

facilitate activities of daily living.

(b)

Related goods must be documented in the SSP, comply with 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. If the eligible recipient requests a good or service, the consultant TPA and MAD 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

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:

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

(ii)
be a licensed and insured contractor or approved vendor that provides construction and remodeling services;

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

(iv)
provide consultation to family members, mi via providers and contractors concerning environmental modification projects to the eligible recipient's residence; and

(v)
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 $5,000 every five years. An eligible recipient transferring into the mi via program will carry his or her history for the previous five years of MAD reimbursed environmental modifications. 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, 3/1/2016]

8.314.6.16 NON-COVERED SERVICES: The waiver does not pay for the purchase of goods or services that a household without a person with a disability would be expected to pay for as a routine household or personal expense. 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, rules 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:

(1) including property-related costs, such as rental or purchase of real estate and furnishing, maintenance, utilities and utility deposits; and

(2) related administrative expenses; utilities include gas, electricity, propane, fire wood, wood pellets, water, sewer, and waste management;

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

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

G. any goods or services that are considered primarily recreational or diversional in nature;

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, cell phone, 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

(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)
Singular or in combination of adaptations include:

(i)
the installation of ramps and grab-bars;

(ii)
widening of doorways and hallways;

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

(iv)
installation of lifts or elevators; modifications of a bathroom facility, such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals, bidet adaptations and plumbing;

(v)
turnaround space adaptations;

(vi)
specialized accessibility and safety adaptations or additions;

(vii)
trapeze and mobility tracks for home ceilings; automatic door openers and doorbells;

(viii)
voice-activated, light-activated, motion-activated, and other such electronic devices;

(ix)
fire safety adaptations;

(x)
air filtering devices; heating and cooling adaptations;

(xi)
glass substitute for windows and doors;

(xii)
modified switches, outlets or environmental controls for home devices; and alarm and alert systems or signaling devices.

(b)
eligible recipient's AAB and advance outcomes in the eligible recipient's SSP.

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

(f)
Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of federal financial participation (FFP) for waiver services.

or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses; mileage or driver time reimbursement for vacation travel by automobile;

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, including laptops or any electronic tablets, 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; an eligible recipient transferring into the mi via program will carry his or her history for the previous three years of MAD reimbursed consumer electronics;

X. cell phone services that include more than one cell phone line per eligible recipient; cell phone service, including cell phone service that includes data, is limited to the cost of one hundred dollars per month;

Y. dental services utilizing mi via individual budgetary allotments.

[8.314.6.16 NMAC - Rp, 8.314.6.16 NMAC, 3/1/2016]

8.314.6.17 SERVICE AND SUPPORT PLAN (SSP) AND AUTHORIZED ANNUAL BUDGET(AAB): A SSP and an annual budget request are developed at least annually by the 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 eligible recipient, assisting the eligible recipient to understand the mi via program, and with developing and implementing the SSP and the AAB. The SSP and annual budget request are developed and implemented as specified in 8.314.6 NMAC and mi via 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. This process 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 his or her SSP. If the eligible recipient 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, behavioral health, adaptive behavior skills, nutritional, functional, community/social and employment; LOC assessments are conducted in person and take place in the eligible recipient's home, or in a HSD approved location.

(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 or 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.

(2) Pre-planning:

(a) The consultant contacts the eligible recipient upon his or her choosing enrollment in the mi via program to provide information regarding this program, 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 re-determining 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 mi via services that are furnished to the 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 or 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 mi via services in meeting the needs of the eligible recipient;

(d)

methods for coordination with the medicaid 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 or her qualifying condition or disability;

(g) information, resources or training needed by the eligible recipient and service providers;

(h) methods to address the eligible recipient's health and safety, such as 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 his or her 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; a job description 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 emergency and back-up plans are complete; and

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

B. Individual budgetary allotment (IBA): Each eligible recipient's annual IBA is determined by MAD or its designee as follows.

(1) Budgetary allotments are based on calculations developed by MAD for each mi via population group, utilizing historical traditional waiver care plan authorized budgets within the population, minus the case management costs, and minus a ten percent discount.

(2) The determination of each 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) An 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 website under fee schedules as well as on the DOH website under mi via, 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 or 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 must address the eligible recipient's clinical, functional, medical or habilitative needs; and

(2) the services or goods must accommodate the eligible recipient in managing his or her household; or

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

(4) the services or goods must promote the eligible recipient's personal health and safety; and

(5) the services or goods must afford the eligible recipient an accommodation for greater independence; and

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

(7) the services or goods must be documented in the SSP and advance the desired outcomes in the eligible recipient's SSP; and

(8) 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

(9) the services or goods must decrease the need for other MAD services; and

(10) the eligible recipient receiving the services or goods does not have the funds to purchase the services or goods; or

(11) 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

(12) the

service or good is not prohibited by federal regulations, NMAC rules, billing instructions, standards, and manuals; and

(13) each service or good must be listed as an individual line item whenever possible; however, when a service or a good 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 work week.

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., a 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-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 calendar days of expiration of the current SSP.

F. Modifications to the eligible recipient's 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 for the eligible recipient, budget revisions may not be submitted to the TPA for review within the last 60 calendar 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 or 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 or her consultant.

(3) If the eligible recipient requests an increase in his or her budget above his or her annual IBA, or AAB, as applicable, the eligible recipient must show at least one of the following four 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; and 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; the eligible recipient must submit a written, dated, and signed evaluation or letter from a medical doctor (MD), doctor of osteopathy (DO), a certified nurse practitioner (CNP) or a physician assistant (PA) that documents the chronic physical condition in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the chronic physical conditions 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; or 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 a NF or ICF-IID;

(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; which require frequent and ongoing management or monitoring or oversight of medical technology;

(b) **change in physical status:** the eligible recipient has experienced a deterioration or permanent change in his or her health status such that the eligible recipient's needs for services and supports can no longer be met within the IBA, current AAB or other current resources, including natural supports, medicaid state plan services, medicare or other sources; the eligible recipient must submit a written, dated, and signed evaluation or letter from a MD, OD, CNP, or PA that documents the change in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation by

others involved in the eligible recipient's care, such as a current individual service plan (ISP) 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; types of physical health status changes that may necessitate an increase in the IBA or current AAB are as follows:

(i) the eligible recipient now requires the administration of medications via intravenous or injections on a daily or weekly basis;

(ii) the eligible recipient has experienced recent onset or increase in aspiration of saliva, foods or liquids;

(iii) the eligible recipient now requires external feedings, e.g. naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube;

(iv) the eligible recipient is newly dependent on a ventilator;

(v) the eligible recipient now requires suctioning every two hours, or more frequently, as needed;

(vi) the eligible recipient now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; or

(vii) the eligible recipient now requires increased assistance with activities of daily living as a result of a deterioration or permanent changes in his or her physical health status;

(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 or 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 or cognitive difficulties are so severe and intense that they result in considerable risk to the eligible recipient, caregivers or the community; and 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; in addition, these behaviors are likely to lead to incarceration or admission to a hospital, nursing facility or ICF-IID; require intensive intervention or medication management by a doctor or behavioral health practitioner or care practitioner which cannot be effectively addressed within the IBA, current AAB or other resources, including natural supports, the medicaid state plan services, medicare or other sources;

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

(ii) the eligible recipient must submit a written, dated, and signed evaluation or letter from a licensed MD, doctor of osteopathy (DO), CNP, physician assistant (PA), psychiatrist, or RLD licensed psychologist that documents the change in the eligible recipient's behavioral health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation including a current ISP 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 intellectual or developmental disabilities, 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 or 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 services, medicare, other programs or sources in order for the eligible recipient to live in a home and community-based setting.

(4) The 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 8.314.6 NMAC and its service standards, the eligible recipient is assisted by his or her consultant in development and implementation of the SSP and AAB. The FMA assists the eligible recipient with implementation of the AAB. Once implemented, a debit card will be utilized for related good listed on an IBA. The process for loading funding on the debit card is as follows:

(1) following the approval of the SSP by the TPA, the

eligible recipient must submit an invoice to the FMA;

(2) the FMA will verify the accuracy of the invoice, then load the funding onto the debit card for use by the eligible recipient;

(3) the eligible recipient must utilize the funding for the approved related good only and maintain the receipt of purchase for a period of up to six years;

(4) the FMA shall schedule and perform random audits of purchases;

(5) if requested, the eligible recipient must provide verification of the purchase to the FMA within three working days.

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 8.314.6 NMAC and mi via service standards and in accordance with 8.302.5 NMAC.

(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 15 working days from the date of the request to respond with 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, 3/1/2016]

8.314.6.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under the mi via program, are subject to utilization review for medical necessity and program requirements. Reviews by 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 8.310.2 NMAC.

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-IID. Prior authorization of services does not guarantee that applicants or eligible recipients are eligible for MAP or mi via services.

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 reconsideration from the TPA that performed the initial review and issued the initial decision. Reconsideration must be requested within 30-calendar days of the date on the denial notice, 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 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, 3/1/2016]

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, employees, and vendors.

B. Claims must be billed to the FMA per the billing instructions. Reimbursement to a service provider and a vendor in the mi via program is made, as follows:

(1) mi via service provider and vendor must enroll with the FMA;

(2) the eligible recipient receives instructions and documentation forms necessary for a service provider's and a vendor's claims processing;

(3) an eligible recipient must submit claims for payment of his or her mi via service provider and vendor to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;

(4) the eligible recipient and his or her mi via service provider and vendor must follow all FMA billing instructions; and

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

C. The FMA must submit claims that have been paid by the FMA on behalf of eligible recipient to the MAD fiscal contractor for processing.

D. Reimbursement may not be made directly to the eligible recipient, either to reimburse him or 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, 3/1/2016]

8.314.6.20 RIGHT TO A HSD ADMINISTRATIVE HEARING:

A. MAD must grant an opportunity for a HSD administrative hearing as described in 8.314.6.20 NMAC in the following circumstances and pursuant to 42 CFR Section 431.220(a)(1) and (2), Section 27-3-3 NMSA 1978 and 8.352.2 NMAC:

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

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

(3) when an applicant is denied the services of his or her choice or the provider of his or her choice;

(4) when an eligible recipient's services are denied, suspended, reduced or terminated;

(5) when an eligible recipient has been involuntarily terminated from the program;

(6) when an eligible recipient's request for a budget adjustment has been denied; and

(7) when any other adverse action is taken by MAD against the eligible recipient, see 8.352.2 NMAC.

B. DOH and its counsel, if necessary, shall participate in any relevant HSD administrative hearing involving an eligible recipient. HSD's office of general counsel may elect to participate in the administrative hearing. See 8.352.2 NMAC for a complete description, instructions, and hearing process of a HSD administrative hearing for an eligible recipient.
[8.314.6.20 NMAC - Rp, 8.314.6.20 NMAC, 3/1/2016]

8.314.6.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to an eligible recipient who requests a HSD administrative hearing within the timeframe defined in 3.352.2 NMAC. The notice will include information on the right to continue the eligible recipient's benefits and on his or her responsibility for repayment if the HSD administrative final hearing decision is not in the eligible recipient's favor. See 8.352.2 NMAC for a complete description of the continuation of benefits process of a HSD administrative hearing for an eligible recipient.

B. The continuation of a benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the eligible recipient's current allocation, budget or LOC. The continuation budget may not be revised until the conclusion of the HSD administrative hearing process unless one of the criteria to modify the budget in 8.314.6.17 NMAC is met. See 8.352.2 NMAC for a complete description, instructions and process of a HSD administrative hearing and continuation of benefits process of a MAP eligible recipient.
[8.314.6.21 NMAC - Rp, 8.314.6.21 NMAC, 3/1/2016]

8.314.6.22 GRIEVANCE/ COMPLAINT SYSTEM: An eligible recipient has the opportunity to register a grievance or complaint concerning the mi via program. An eligible recipient may register complaints with DOH via e-mail, mail or phone. Complaints will be referred to the appropriate DOH division or as appropriate referred to MAD for resolution. The filing of a complaint or grievance does not preclude an eligible recipient from pursuing a HSD administrative hearing. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for requesting a HSD administrative hearing.
[8.314.6.22 NMAC - Rp, 8.314.6.22 NMAC, 3/1/2016]

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.
8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 10/2/2012 - Repealed effective 3/1/2016.

REGULATION AND LICENSING DEPARTMENT

SIGNED LANGUAGE INTERPRETING PRACTICES BOARD

This is an amendment to 16.28.3 NMAC, Section 20, effective 2/29/16.

16.28.3.20 LICENSE DENIAL, SUSPENSION, OR REVOCATION:

A. In accordance with procedures contained in the Uniform Licensing Act [61-1-1 NMSA 1978], the board may deny, revoke or suspend a license held or applied for under the Signed Language Interpreting Practices Act, upon grounds that the licensee or applicant:

(1) is guilty of fraud or deceit in procuring or attempting to procure a license;

(2) is guilty of gross incompetence;

(3) is guilty of unprofessional or unethical conduct as defined by rule of the board;

(4) uses untruthful or misleading advertising;

(5) is habitually or excessively using controlled substances or alcohol to such a degree the licensee or applicant is rendered unfit to practice as a signed language interpreter pursuant to the Signed Language Interpreting Practices Act;

(6) has violated the Signed Language Interpreting Practices Act;

(7) is guilty of aiding and abetting a person not licensed to practice signed language interpreting pursuant to the Signed Language Interpreting Practices Act; or

(8) as evidenced by a certified copy of the record of jurisdiction, has had a license, certificate or registration to practice signed language interpreting revoked, suspended or denied in any state or territory of the United States for actions pursuant to this section.

B. Disciplinary proceedings may be initiated by a complaint of a person, including members of the board, and shall conform with the provisions of the Uniform Licensing Act.

C. A person filing a complaint shall be immune from liability arising out of civil action if the complaint is filed in good faith and without actual malice.

D. In the event that a community or educational license is issued in error [~~by an interpreter,~~] and if the interpreter is qualified for a provisional license the permitted five (5) years for the provisional license shall began at the time of the issuance of the improperly issued license.
[16.28.3.20 NMAC - N, 12/16/15; A, 2/29/16]

TAXATION AND REVENUE DEPARTMENT

TITLE 3: TAXATION
CHAPTER 28: TAX FRAUD ENFORCEMENT
PART 2: STANDARD OF CONDUCT FOR COMMISSIONED PERSONNEL AND TFID EMPLOYEES ACTIVELY PURSUING COMMISSION

3.28.2.1 ISSUING AGENCY: Taxation and Revenue Department, Joseph M. Montoya Building, 1100 South St. Francis Drive, P.O. Box 630, Santa Fe NM 87504-0630.
[3.28.2.1 NMAC - N, 2/29/16]

3.28.2.2 SCOPE: This part applies to all certified law enforcement officers commissioned as tax fraud enforcement officers by the New Mexico taxation and revenue department's tax fraud investigations division and employees of the taxation and revenue department's tax fraud investigations division who are actively pursuing their commissions pursuant to the requirements

of Section 29-7-6 NMSA 1978.
[3.28.2.2 NMAC - N, 2/29/16]

3.28.2.3 STATUTORY AUTHORITY: Section 9-11-14 NMSA 1978.
[3.28.2.3 NMAC - N, 2/29/16]

3.28.2.4 DURATION: Permanent.
[3.28.2.4 NMAC - N, 2/29/16]

3.28.2.5 EFFECTIVE DATE: February 29, 2016, unless a later date is cited at the end of a section.
[3.28.2.5 NMAC - N, 2/29/16]

3.28.2.6 OBJECTIVE: The objective of this part is to provide standards of conduct for commissioned tax fraud enforcement officers of the New Mexico taxation and revenue department's tax fraud investigations division (TFID), as authorized by the provisions of Section 9-11-14 NMSA 1978 of the Taxation and Revenue Department Act and for non-commissioned employees of the TFID who are actively pursuing their commissions pursuant to the requirements of Section 29-7-6 NMSA 1978.
[3.28.2.6 NMAC - N, 2/29/16]

3.28.2.7 DEFINITIONS: As used in Section 9-11-14 NMSA 1978 and in this part:

A. "Academy" means a law enforcement academy that offers accredited courses and curricula for law enforcement officer certification;

B. "Certified firearms instructor" is an individual who is certified by the New Mexico department of public safety to instruct and test individuals on the use of firearms;

C. "Certified law enforcement officer" is an individual who has received a certification from the New Mexico law enforcement academy board;

D. "Code of conduct" means the department's code of conduct for all employees;

E. "commissioned personnel" means any commissioned tax fraud enforcement officer with the TFID;

F. "Days" means, unless otherwise stated, that days will be considered to be working days, or days which are regularly scheduled to be worked. For suspension purposes, a holiday is considered to be a working day;

G. "Department" means the New Mexico taxation and revenue department;

H. "Employee" means certified and commissioned tax fraud enforcement officers within the TFID who are vested by law with a duty to maintain public order or make arrests for crimes, as limited herein to crimes associated with violations of the Tax Administration Act, and non-commissioned TFID employees while they are actively pursuing commission;

I. "Firearm" means one of the following:

(1) revolver or semi-automatic handgun, issued or personal; must be a glock .40 caliber or other caliber which is approved and authorized by the appropriate chain of command within TFID;

(2) shotgun, issue only, 12 gauge, which is approved and authorized by the appropriate chain of command within the TFID; or

(3) special team weapon identified, approved and authorized by the appropriate chain of command within the TFID;

J. "New Mexico law enforcement academy board" means the board created by Section 29-7-3 NMSA 1978;

K. "Non-commissioned employee" means TFID employees actively pursuing their commissions pursuant to the requirements of Section 29-7-6 NMSA 1978;

L. "Order" means a lawful authoritative command, either verbal or written;

M. "Policy" means a mandatory guide designated to meet a situation and circumstance;

N. "Procedures" means a written method which delineates the implementation of a policy;

O. "Qualification" means the process established by the department of public safety for a certified firearms instructor to test a candidate's firearm skills;

P. "Secretary" means the cabinet secretary of the New Mexico taxation and revenue department;

Q. "Suspension" means an involuntary leave of absence without pay for disciplinary reasons for a period not to exceed 30 calendar days;

R. "Tax fraud enforcement officer" means a certified law enforcement officer who has been commissioned by the secretary to investigate fraud and other crimes that may affect the collection of taxes due to the state;

S. "Termination" means the act of permanently terminating the service of a commissioned tax fraud enforcement officer; a discharge or removal from position of hire, for cause, pursuant to provisions of the Personnel Act (Chapter 10, Article 9 NMSA 1978), as applicable to all employees of the department pursuant to Section 9-11-10 NMSA 1978; and

T. "TFID" means the tax fraud investigations division of the New Mexico taxation and revenue department.
[3.28.2.7 NMAC - N, 2/29/16]

3.28.2.8 STANDARD OF CONDUCT: All employees are expected to adhere to the provisions of this rule and are subject to such disciplinary action for violation of any of these rules as deemed appropriate by their supervisors or the secretary of the department.

A. Employees shall obey all:

(1) laws of the United States, or any state and local jurisdiction in which the employees are present; and

(2) department and TFID code of conduct, rules and regulations, policies, procedures, directives and lawful orders issued by supervisors.

B. Employees shall satisfactorily perform their duties and assume the responsibilities of their positions. Unsatisfactory performance may be demonstrated by violating any one of the following provisions:

(1) a lack of knowledge of the application of laws required to be enforced;

(2) an unwillingness or inability to perform assigned tasks; or

(3) the failure to conform to work standards established to the employees' rank, grade or position as set forth in the job specifications.

C. Employees shall conduct themselves at all times, both on and off duty, in such a manner as to reflect most favorably on the department. Conduct unbecoming an employee shall include that which brings the department into disrepute or reflects discredit upon the employee as a member of the department, or that which impairs the operation or efficiency of the department or employee. Employees are subject to all rules, policies, and the code of conduct of the department, and, in addition:

(1) employees shall carry out all proper, lawful orders given them by supervisors in the line of duty without hesitation or criticism.

Employees will take up matters affecting themselves, their position and departmental business with their immediate supervisor, or through their chain of command or through other TFID designated and proper channels;

(2) employees shall promptly obey any lawful orders of any supervisor. This will include orders relayed from a supervisor by an employee of the same rank or a subordinate employee;

(3) employees who are given an otherwise lawful and proper order which is in conflict with a previous order, rule, regulation or directive shall respectfully inform the supervisor issuing the conflicting order. If the supervisor issuing the order does not alter or retract the conflicting order, the new order shall stand. Under these circumstances, the responsibility for the conflict shall be upon the supervisor. Employees shall obey the conflicting order and shall not be held responsible for disobedience of the order, rule, regulation or directive previously issued;

(4) employees shall not obey any order which they know or should know would require them to commit any illegal act. If in doubt as to the legality of an order, employees shall request the issuing supervisor to either clarify the order or to confer with higher authority;

(5) all employees shall be courteous to the public, supervisors and all other employees, as well as any person the employee has contact with during the performance of his/her duties and responsibilities. Employees shall be tactful in the performance of their duties, shall control their tempers, and exercise the utmost patience and discretion, and shall not engage in argumentative discussions even in the face of extreme provocation. In the performance of their duties, employees shall not use coarse, violent, profane, or insolent language or gestures, and shall not express any prejudice concerning race, religion, politics, national origin, sex, lifestyle, or similar characteristics. When any person requests assistance or advice, all pertinent information will be obtained in an official and courteous manner and will be properly and judiciously acted upon; and

(6) employees shall maintain a level of good moral character in their personal and business affairs, which is in keeping with the highest standards of the law enforcement profession. Employees shall not participate in any incident which impairs their ability to perform their duties or impedes the operation of the department or causes the department to be brought into disrepute. An employee's direct supervisor shall determine if an employee is fit for duty.

D. Employees will properly care for and maintain all state equipment issued to or used by the employee.

E. An employee will not represent themselves as speaking on behalf of the department in any court proceeding, civil or criminal, for purpose of being a character witness.

F. All employees shall follow all applicable rules and protocols established by the department as regards to confidentiality of taxpayer and motor vehicle division information.

G. Commissioned tax fraud enforcement officers shall carry their badges and commissions on their person at all times, while on duty or while carrying a loaded concealed firearm off duty as provided by the department's policy and procedures. Commissioned tax fraud enforcement officers shall furnish their name to any person requesting that information when they are on duty or while representing themselves in an official capacity, except when the withholding of such information is necessary for the performance of law enforcement officer or department duties.

H. Employees shall submit all necessary reports and official documents on time and in accordance with established documents and in accordance with established departmental or TFID procedures. Reports and documents submitted by employees shall be truthful and complete, and no employees shall knowingly enter or cause to be entered any inaccurate, false, or improper information. All departmental law enforcement reports, records and evidence are privileged and confidential and may be released only upon written authority of the secretary, and by verbal authority if written authority cannot reasonably be obtained except as required by court order.

I. All employees are expected to meet their financial obligations in a timely manner and live within their financial means. This does not preclude any employee from properly proceeding in bankruptcy.

J. The purpose of this subsection is to provide direction and guidance regarding supplemental employment.

(1) Supplemental employment includes any tasks performed for which the employee is compensated in any way.

(2) Employees who wish to obtain supplemental employment shall secure written permission from their direct supervisor.

(3) In addition to department policies regarding supplemental employment, TFID may impose specific additional conditions on TFID employees.

(4) This subsection applies to all TFID employees including those on any type of leave or suspension.

K. All employees will be physically and mentally fit for duty. The secretary or the employee's direct supervisor may order a physical or psychological examination to assure compliance with this rule, and may mandate counseling or coursework to assist an employee to meet appropriate standards.

L. Employees will not accept anything, including, but not limited to loans, offered to them which is intended to influence the employee in the performance of their duties and responsibilities or for tasks performed as part of their duties.

M. The purpose of this subsection is to provide direction and guidance to all employees regarding political activity.

(1) While off duty and not representing the department, employees shall be permitted to:

(a) express opinion(s) as individuals on political issues and candidates;

(b) attend political conventions, rallies, fund raising functions and similar political gatherings in an unofficial capacity;

(c) actively engage in any non-partisan political function, partisan meaning an adherent to a party, faction, cause or person; actively engaging in activities of private, fraternal or social organizations which do not conflict with the mission of the department and associated responsibilities is permissible;

(d) sign political petitions as individuals;

(e) make financial contributions to political organizations;

(f) perform non-partisan duties as prescribed by state or local laws;

(g)

hold membership in a political party and participate in its functions to the extent consistent with the law and consistent with this regulation; and

(h) otherwise participate fully in public affairs, except as provided by law, to the extent that such endeavors do not impair the neutral and efficient performance of official duties, or create real or apparent conflicts of interest.

(2) Employees are prohibited at all times from:

(a) using their official capacity to influence, interfere with, or affect the results of an election;

(b) assuming active roles in management, organization or financial activities of partisan political clubs, campaigns or parties;

(c) serving as officers of partisan political parties and clubs;

(d) becoming candidates for, seeking election to, or running for, or campaigning for, a partisan elective public or political office;

(e) soliciting votes in support of, or in opposition to, any partisan candidates;

(f) serving as delegates to a political party convention;

(g) endorsing or opposing a partisan candidate for public office in a political advertisement, broadcast or campaign literature;

(h) initiating or circulating a partisan nominating petition;

(i) organizing, selling tickets to, or actively participating in a fund-raising function for a partisan political party or candidate;

(j) addressing political gatherings in support of, or in opposition to, a partisan candidate; and

(k) otherwise engaging in prohibited partisan activities on the federal, state, county or municipal level.

N. In their capacity as department employees, employees will not seek self-publicity through the news media or any other media by furnishing information obtained or generated from their work for the department for the primary purpose of personal publicity.

O. Employees will not use their position or permit use of their position for personal or financial gain whether directly or indirectly for themselves or any other individual or group.

P. All commissioned tax fraud enforcement officers shall use the utmost care and caution in handling firearms at all times. The following regulate the authorized use of a firearm. An employee shall use their department issued firearm:

(1) as authorized by department use of force and carrying of firearms policies or any other department policy and procedure, drawing or displaying the firearm only for a legal use or for inspection (including cleaning, oiling and storing);

(2) for practice, preferably on an approved range under the auspices of an approved range master; however, should an approved range master not be available, the employee may, at his or her discretion, still utilize the approved range for target practice;

(3) to kill a critically wounded or dangerous animal, when other disposition is impractical; or

(4) to give an alarm or call for assistance for an important purpose when no other means can be used.

Q. In every instance in which a commissioned tax fraud enforcement officers discharges a firearm while on duty, with the exception of target practice, the employee will, without delay, make a written report as required by TFID protocols. The secretary will be apprised of all incidents of discharged firearms other than target practice. Any unauthorized discharge of a firearm could result in disciplinary action up to and including termination. Any unauthorized use or discharge of a firearm could result in disciplinary action up to and including termination.

R. Non-commissioned TFID employees who are actively pursuing commission are authorized to use department firearms only:

(1) with a certified firearms instructor for qualification; and

(2) when attending an academy and shall use department firearms only during academy directed exercises, classes and events.

S. Duty issued firearms and other department issued weapons shall not be used off-duty except for duty related matters.

T. Employees will maintain a neat appearance in groom and dress, as required for all department employees by department policy. Other practical requirements may be made so that the employee can properly use duty issued firearms and other department equipment. All additional requirements will be made by employee's supervisors and discussed with the employee prior to implementation.

U. Any and all disciplinary action shall be taken in accordance with the regulations of the state personnel board, department policies and code of conduct and this subsection.

(1) Administrative leave with pay shall not have any effect on a commissioned tax fraud enforcement officer's retention of their department commission;

(2) During all periods of suspension, an employee will be relieved of their commission card and any other TFID identity card; any TFID badge(s); their department issued firearm and firearm holster; and their department issued equipment, including but not limited to department purchased or otherwise owned body armor; insignia garments; investigative accessories; vehicles and computers. During all periods of or discipline based administrative leave taken in accordance with the regulations of the state personnel board, an employee shall not access or attempt to access department e-mail; data bases; or computers; and

(3) If disciplinary action includes termination, a commissioned tax fraud enforcement officer's commission shall be revoked at the time the termination is made pursuant to department policies. In addition to any requirements imposed by department policies, the commissioned tax fraud enforcement officer's commission shall be immediately returned to the department. All terminated employees shall return to the department any TFID identity card; any TFID badge(s); any department issued firearm and firearm holster; and department issued equipment, including but not limited to department purchased or otherwise owned body armor; insignia garments; investigative accessories; vehicles and computers.

V. Any commissioned tax fraud enforcement officer who is relieved of their law enforcement certification will be relieved of their TFID commission.

[3.28.2.8 NMAC - N, 2/29/16]

HISTORY OF 3.28.2 NMAC:
[RESERVED]

WORKFORCE SOLUTIONS, DEPARTMENT OF

This is an amendment to 11.1.2 NMAC, adding Section 20, effective 02-29-2016.

11.1.2.20 PREVAILING WAGE AND FRINGE BENEFIT RATES: Pursuant to 11.1.2.13 NMAC, the Department of Workforce Solutions hereby publishes the attached proposed 2016 prevailing wage and fringe benefit rates that will apply to all wage rate decisions issued from January 1, 2016 to December 31, 2016.

A. Type A: street, highway, utility and light engineering.

Trade Classification	Base Rate	Fringe Rate
Asbestos worker - heat & frost insulator	$31.26	$11.11
Boilermaker	18.50	3.31
Bricklayer/Blocklayer/stonemason	23.32	7.30
Carpenter/lather	23.40	8.62
Millwright/piledriver	31.00	14.56
Cement mason	20.50	9.24
Electricians outside classifications		
Groundman	21.28	10.57
Equipment operator	30.54	12.98
Lineman/tech	35.93	14.23
Cable splicer	39.52	15.13
Inside classifications		
Wireman/tech	29.70	9.94
Cable splicer	32.67	10.03
Glazier	20.15	3.65
Ironworker	31.04	9.40
Painter (brush/roller/spray)	21.17	6.53
Plumber/pipefitter	31.14	11.55
Roofer	19.56	11.34
Sheetmetalworker	28.28	15.37
Operators		
Group I	17.67	5.83
Group II	18.76	5.83
Group III	19.41	5.83
Group IV	19.62	5.83
Group V	19.68	5.83
Group VI	19.82	5.83
Group VII	19.94	5.83
Group VIII	21.38	5.83
Group IX	26.45	5.83
Group X	29.35	5.83
Laborers		
Group I	18.00	5.05
Group II	19.18	5.05
Group III	19.53	5.05
Group IV	19.94	5.05
Group V	20.30	5.05
Group VI	19.03	5.05
Group VII	19.18	5.05
Group VIII	19.43	5.05
Group IX	19.63	5.05

Group X	20.30	5.05
Truck drivers		
Group I	15.05	4.94
Group II	15.25	4.94
Group III	15.45	4.94
Group IV	15.65	4.94

B. Type B: general building

Trade Classification	Base Rate	Fringe Rate
Asbestos worker - heat & frost insulator	31.26	11.11
Boilermaker	21.77	3.98
Bricklayer/blocklayer/stonemason	23.32	7.30
Carpenter/lather	23.40	8.18
Cement mason	19.61	9.57
Electricians outside classifications		
Groundman	21.28	10.32
Equipment operator	30.54	12.64
Lineman/tech	35.93	13.98
Cable splicer	39.52	14.88
Inside classifications		
Wireman/technician	29.90	9.75
Cable splicer	32.89	9.84
Sound classifications		
Installer	23.39	8.31
Technician	28.95	7.52
Soundman	27.01	8.31
Elevator constructor	38.37	28.08
Elevator constructor helper	26.86	28.08
Glazier	20.15	3.65
Ironworker	26.12	13.38
Painter (brush/roller/spray)	16.00	5.18
Paper hanger	16.00	5.18
Drywall finisher/taper	23.40	8.18
Plasterer	21.39	7.66
Plumber/pipefitter	31.14	11.55
Roofer	15.18	0.50
Sheetmetal worker	28.28	15.37
Soft floor layer	23.40	8.18
Sprinkler fitter	27.95	17.87
Tile setter	14.80	1.20
Tile setter helper	13.00	1.02
Laborers		
Group I	15.68	5.40
Group II	16.33	5.40
Group III	17.30	5.40
Group IV	19.53	5.40
Group V	17.60	5.40
Group VI	17.75	5.40
Operators		

Group I	19.57	6.00
Group II	21.53	6.00
Group III	21.95	6.00
Group IV	22.35	6.00
Group V	22.52	6.00
Group VI	22.71	6.00
Group VII	22.82	6.00
Group VIII	25.56	6.00
Truck drivers		
Group I	14.76	6.25
Group II	15.00	6.25
Group III	15.50	6.25
Group IV	15.51	6.25
Group V	15.60	6.25
Group VI	15.75	6.25
Group VII	15.90	6.25
Group VIII	16.11	6.25
Group IX	16.32	6.25

C. Type C: residential

Trade Classification	Base Rate	Fringe Rate
Asbestos worker - heat & frost insulator	31.26	11.11
Boilermaker	21.77	3.98
Bricklayer/blocklayer/stonemason	23.32	7.30
Carpenter/lather	23.40	8.62
Millwright/piledriver	31.00	14.56
Cement mason	16.81	8.71
Electricians outside classifications		
Groundman	21.28	10.57
Equipment operator	30.54	12.98
Lineman/tech	35.93	14.23
Cable splicer	39.52	15.13
Inside classifications		
Wireman/technician	29.70	9.94
Cable splicer	32.67	10.03
Sound classifications		
Installer	10.00	1.01
Technician	28.95	7.52
Soundman	13.62	1.01
Elevator constructor	38.37	28.08
Elevator constructor helper	26.86	28.08
Glazier	20.15	3.65
Ironworker	13.00	6.16
Painter (brush/roller/spray)	11.72	5.18
Paper hanger	12.72	5.18
Drywall finisher/taper	23.40	8.62
Plasterer	17.97	6.59
Plumber/pipefitter	20.04	8.70
Roofer	13.96	1.87

Sheetmetal worker	28.28	15.37
Soft floor layer	23.40	8.62
Sprinkler fitter	27.95	17.87
Tile setter	9.88	0.00
Laborers		
Group I	14.14	5.40
Group II	15.04	5.40
Group III	15.94	5.40
Group IV	16.84	5.40
Group V	16.24	5.40
Group VI	16.39	5.40
Operators		
Group I	11.53	5.45
Group II	15.47	5.45
Group III	15.55	5.45
Group IV	12.69	5.45
Group V	15.67	5.45
Group VI	15.77	5.45
Group VII	15.52	5.45
Group VIII	16.95	5.45
Truck drivers		
Group I	14.88	0.00
Group II	15.00	0.00
Group III	15.08	0.00
Group IV	15.20	0.00
Group V	15.25	0.00
Group VI	15.35	0.00
Group VII	15.45	0.00
Group VIII	15.59	0.00
Group IX	15.74	0.00

D. Type H: heavy engineering

Trade Classification	Base Rate	Fringe Rate
Asbestos worker - heat & frost insulator	31.26	11.11
Boilermaker	18.50	3.31
Bricklayer/Blocklayer/stonemason	23.32	7.30
Carpenter/lather	23.40	8.62
Millwright/piledriver	31.00	14.56
Cement mason	20.50	9.24
Electricians outside classifications		
Groundman	21.28	10.57
Equipment operator	30.54	12.98
Lineman/tech	35.93	14.23
Cable splicer	39.52	15.13
Inside classifications		
Wireman/tech	29.70	9.94
Cable splicer	32.67	10.03
Glazier	20.15	3.65
Ironworker	31.04	9.40

Painter (brush/roller/spray)	21.17	6.53
Plumber/pipefitter	31.14	11.55
Roofer	19.56	11.34
Sheetmetalworker	28.28	15.37
Operators		
Group I	17.67	5.83
Group II	18.76	5.83
Group III	19.41	5.83
Group IV	19.62	5.83
Group V	19.68	5.83
Group VI	19.82	5.83
Group VII	19.94	5.83
Group VIII	21.38	5.83
Group IX	26.45	5.83
Group X	29.35	5.83
Laborers		
Group I	18.00	5.05
Group II	19.18	5.05
Group III	19.53	5.05
Group IV	19.94	5.05
Group V	20.30	5.05
Group VI	19.03	5.05
Group VII	19.18	5.05
Group VIII	19.43	5.05
Group IX	19.63	5.05
Group X	20.30	5.05
Truck drivers		
Group I	15.05	4.94
Group II	15.25	4.94
Group III	15.45	4.94
Group IV	15.65	4.94

[11.1.2.20 NMAC - N, 02-29-2016]

END OF ADOPTED RULES

2016 New Mexico Register

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Issue 6	March 16	March 31
Issue 7	April 1	April 15
Issue 8	April 18	April 30
Issue 9	May 2	May 13
Issue 10	May 16	May 31
Issue 11	June 1	June 15
Issue 12	June 16	June 30
Issue 13	July 1	July 15
Issue 14	July 18	July 29
Issue 15	August 1	August 15
Issue 16	August 16	August 31
Issue 17	September 1	September 15
Issue 18	September 16	September 30
Issue 19	October 3	October 14
Issue 20	October 17	October 31
Issue 21	November 1	November 15
Issue 22	November 16	November 30
Issue 24	December 16	December 30

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