TITLE 8 SOCIAL SERVICES
CHAPTER 315 OTHER LONG TERM CARE SERVICES
PART 4 PERSONAL CARE OPTION SERVICES

8.315.4.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.315.4.1 NMAC - Rp, 8.315.4.1 NMAC, 9-15-10]

8.315.4.2 SCOPE: The rule applies to the general public.
[8.315.4.2 NMAC - Rp, 8.315.4.2 NMAC, 9-15-10]

8.315.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.315.4.3 NMAC - Rp, 8.315.4.3 NMAC, 9-15-10]

8.315.4.4 DURATION: Permanent
[8.315.4.4 NMAC - Rp, 8.315.4.4 NMAC, 9-15-10]

8.315.4.5 EFFECTIVE DATE: September 15, 2010, unless a later date is cited at the end of a section.
[8.315.4.5 NMAC - Rp, 8.315.4.5 NMAC, 9-15-10]

8.315.4.6 OBJECTIVE: The objective of this rule is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.315.4.6 NMAC - Rp, 8.315.4.6 NMAC, 9-15-10]

8.315.4.7 DEFINITIONS: [RESERVED]

8.315.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[8.315.4.8 NMAC - Rp, 8.315.4.8 NMAC, 9-15-10]

8.315.4.9 PERSONAL CARE OPTION SERVICES: Personal care option (PCO) services have been established by the New Mexico human services department (HSD), medical assistance division (MAD) to assist individuals 21 years of age or older who are eligible for full medicaid coverage. PCO services are for qualified individuals who satisfy medicaid program requirements and meet the nursing facility level of care criteria pursuant to Attachment II of 8.312.2-UR, *long term care services utilization review instructions for nursing facilities*. These utilization review instructions can be obtained from MAD. These regulations describe program service options and corresponding eligible providers, eligible populations, covered PCO services, non-covered services, the assessment and utilization review process, transfer process, discharge process and provider reimbursement, when appropriate, state designee(s) or contractors. Personal care services for individuals under the age of 21 are reimbursed by the New Mexico medicaid program through the early periodic screening, diagnostic and treatment (EPSDT) services described in 8.323.2 NMAC, *EPSDT Personal Care Services*.

A. The goals of PCO services are to avoid institutionalization, maintain or increase the individual's functional level and maintain or increase the individual's independence. The PCO program does not provide services 24 hours a day.

B. An individual may be physically capable of performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs) but may have limitations in performing these activities because of a cognitive impairment. PCO services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. In such cases, personal care may include cueing along with supervision to ensure that the individual performs the task properly. PCO is a medicaid service, not a medicaid category of assistance, and services under this option are delivered pursuant to an individual plan of care (IPoC). PCO services include a range of services to consumers who are unable to perform some/all ADLs or IADLs because of a disability or a functional limitation(s). PCO services permit an individual to live in his or her residence rather than an

institution and allow him or her to maintain or increase independence. These services include, but are not limited to, bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, cognitive assistance and communicating.

C. Individuals eligible for PCO services have the option of choosing the consumer-directed personal care model or the consumer-delegated personal care model. Under both models, the consumer may select a family member (except a spouse), friend, neighbor or other individual as the attendant. The consumer-directed model allows the consumer to act as the employer, and oversee his/her own service care delivery, and requires the consumer to work with a fiscal intermediary agency to process all financial paperwork to medicaid or its designee, coordination of long-term services (CoLTS) managed care organization (MCO). Under the consumer-delegated model, the consumer chooses the agency to perform all employer-related tasks and the agency is responsible for ensuring all service delivery to the consumer.

D. The third-party assessor (TPA) or medicaid's CoLTS MCO, or other medicaid designee is responsible for explaining both models to each individual initially and annually thereafter, assessing each individual applying for PCO services, making a medical level of care (LOC) determination and allocating PCO services based on that individual's needs. Medicaid-eligible individuals or their personal representatives (as defined in 8.300.2.7 NMAC) may contact their TPA to apply for PCO services.

[8.315.4.9 NMAC - Rp, 8.315.4.9 NMAC, 9-15-10]

8.315.4.10 CONSUMER-DIRECTED PERSONAL CARE: HSD has established consumer-directed personal care for PCO services to allow consumers the option of directing their own care. The consumer or the consumer's personal representative retains responsibility for performing certain employer-related tasks.

A. **The consumer's or their personal representative's responsibilities include:**

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

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

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

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

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

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

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

(5) notifying and submitting a report of an incident to the agency within 24 hours of such incident, so that the agency can submit an incident report as directed in the standards manual on behalf of the consumer; the consumer or his/her personal representative is responsible for completing the incident report;

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

(7) obtaining from the attendant a signed agreement, in which the attendant agrees that he or she will not provide PCO services while under the influence of drugs or alcohol and, therefore, acknowledges that if he or

she is under the influence of drugs or alcohol while providing PCO services he or she will be immediately terminated; the consumer or his personal representative shall not employ an attendant who has previously been terminated from employment for use of drugs or alcohol while providing PCO services;

(8) ensuring that if the attendant is the consumer's legal guardian or attorney- in-fact and is the elected individual for hire, prior approval has been obtained from MAD or its designee; any PCO services provided by the consumer's legal guardian or attorney-in-fact *MUST* be justified, in writing, by the PCO agency and consumer and submitted for approval to MAD or its designee prior to employment; the justification must demonstrate and prove the lack of other qualified attendants in the applicable area; documentation of approval by MAD or its designee must be maintained in the consumer's file; the consumer is responsible for immediately informing the agency if the consumer has appointed or elects a legal guardian or attorney-in-fact any time during the plan year;

(9) taking the medical assessment form (MAD 075) or successor document once a year to his or her doctor and submitting it to the TPA or alternative medicaid designee for review; this must be done 60 days prior to his or her level of care (LOC) expiring to ensure that there will be no break in services; a consumer who does not submit a timely MAD 075 may experience a break in service.

B. **The consumer-directed personal care agency's responsibilities include:**

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

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

(3) maintaining appropriate recordkeeping of services provided and fiscal accountability as required by the provider participation agreement (PPA), also known as the MAD 335;

(4) maintaining records, as required by the PPA, also known as the MAD 335 and as outlined in 8.302.1 NMAC, *General Provider Policies*, that are sufficient to fully disclose the extent and nature of the services furnished to the consumers;

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

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

(7) furnishing their consumers, upon request, with information regarding each model; if the consumer chooses a model that an agency does not offer, the agency must refer the consumer to an agency that offers that model; the TPA is responsible for explaining each model in detail to consumers on an annual basis;

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

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

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

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

(12) verifying that the consumer has elected the consumer's legal guardian or attorney-in-fact as the attendant, the consumer has obtained prior approval from MAD or its designee; any personal care services provided by the consumer's legal guardian or attorney-in-fact *MUST* be justified, in writing, by the agency and consumer and submitted for approval to MAD or its designee prior to employment; the justification must demonstrate and prove the lack of other qualified attendants in the applicable area; documentation of approval by MAD or its designee must be maintained in the consumer's file; the agency must inform the consumer that if the consumer is appointed or elects a legal guardian or attorney-in-fact any time during the plan year, the consumer must notify the agency immediately and the agency must ensure appropriate documentation is maintained in the consumer's file;

(13) producing reports or documentation as required by the department or its designee;

(14) verifying that consumers will not be receiving services through the following programs while they are receiving PCO services: a medicaid home and community-based services waiver (HCBSW) except for CoLTS (c) waiver services, formerly known as the Disabled and Elderly (D&E) HCBS waiver, medicaid certified nursing facility (NF), intermediate care facility/mentally retarded (ICF/MR), program of all-inclusive care for the elderly (PACE), or aging and long term services department (ALTSD) adult protective services (APS) attendant care program; an individual residing in a NF or ICF/MR or receiving community-based services is eligible to apply for PCO services; all individuals must meet the financial/medical eligibility requirements to receive PCO services; the TPA, medicaid, or its designee must conduct an assessment or evaluation to determine if the transfer is appropriate and if the PCO program would be able to meet the needs of that individual;

(15) processing all claims for PCO services; payment shall not be issued without appropriate documentation;

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

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

(18) performing payroll activities for the attendants, such as, but not limited to, income tax and social security withholdings;

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

(20) arranging for state of New Mexico workers' compensation insurance for all attendants;

(21) informing the consumer of available resources for necessary training, if requested by the consumer, in the following areas:

(a) hiring, recruiting, training, and supervision of attendants, including advertising and interviewing techniques; and

(b) evaluating methods of attendant competence and effectiveness;

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

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

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

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

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

(a) death:

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

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

(b) other reportable incidents:

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

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

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

(iv) any reports made to APS;

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

(25) informing the consumer, within the 90-day time period prior to the IPoC expiring, a minimum of three times, that his/her annual review is due and he/she must submit medical documentation, including the medical assessment form (MAD 075), to the TPA for level-of-care determination and to ensure that a break in services does not occur; documentation must be in the consumer's file demonstrating the consumer was informed.

C. **Eligible consumer-directed agencies:** PCO agencies must be certified by medicaid or its designee. An agency listing, by county, is maintained by medicaid or its designee. All certified PCO agencies are required to select a county in which to establish and maintain an official office for conducting of business with published phone number and hours of operation; the PCO agency must provide services in all areas of the county in which the main office is located. The PCO agency may elect to serve any county within 100 miles of the main office. The PCO agency may elect to establish branch office(s) within 100 miles of the main office. The PCO agency must provide PCO services to all areas of any county(ies) selected to provide services. To be certified by medicaid or its designee, agencies must meet the following conditions and submit a packet (contents (1) - (6) described below) for approval to medicaid's fiscal agent or its designee containing the following:

(1) a completed medicaid provider participation application (MAD 335);

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

(3) a copy of a current/valid business license or evidence of non-profit status; after certification, a copy of the business license/evidence of non-profit status must be kept current and submitted annually;

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

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

(a) medicaid's PCO provider policies;

(b) personnel policies; and

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

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

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

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

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

(i) service delivery;

(ii) operational activities;

(iii) quality improvement action plan; and

(iv) documentation of activities;

(e) agency operations to furnish services either as a fiscal intermediary or as an agency with choice;

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

(7) after the packet is received and reviewed by medicaid or its designee, the agency will be contacted to complete the rest of the certification process; this will require the agency to:

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

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

(8) any professional authorized to complete the medical assessment form (MAD 075) cannot also become a PCO agency.

D. **The consumer-directed personal care attendant responsibilities and requirements include**:

(1) being hired by the consumer;

(2) not being the spouse or minor child of the consumer pursuant to 42 CFR Section 440.167 and the centers for medicare and medicaid services (CMS) state medicaid manual section 4480-D;

(3) providing the consumer with proof of and copies of current/valid driver's license and motor vehicle insurance policy if the attendant will be transporting the consumer;

(4) being 18 years of age or older;

(5) ensuring that if the attendant is the consumer's legal guardian or attorney-in-fact and is the elected individual for hire, prior approval has been obtained from MAD or its designee; any PCO services provided by the consumer's legal guardian or attorney-in-fact *MUST* be justified, in writing, by the agency and consumer and submitted for approval to MAD or its designee prior to employment; the justification must demonstrate and prove the lack of other qualified attendants in the applicable are; documentation of approval by MAD or its designee must be maintain in the consumer's file;

(6) successfully passing a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act, performed by an agency certified to conduct such checks; attendants are required to submit to a criminal history screening within the first 20 calendar days of hire; an attendant may be conditionally (temporarily) hired by the consumer contingent upon the receipt of written notice from the certified agency of the results of the nationwide caregiver criminal history screening; attendants who do not successfully pass a nationwide criminal history screening are not eligible for continued PCO employment; and

(7) ensuring while employed as an attendant he/she will not be under the influence of drugs or alcohol while performing PCO services; the attendant must complete and sign an agreement with the consumer or the consumer's personal representative in which the attendant acknowledges that if he/she is under the influence of drugs or alcohol while providing PCO services he will be immediately terminated; attendants who have been terminated for use of drugs or alcohol while providing PCO services are not eligible for further PCO services.

[8.315.4.10 NMAC - Rp, 8.315.4.10 NMAC, 9-15-10]

8.315.4.11 CONSUMER-DELEGATED PERSONAL CARE: HSD has established consumer delegated PCO services, to allow consumers the option of selecting an agency to provide services and perform employer related tasks. The agency contracts with medicaid or its designee to perform these tasks. This section defines eligible agencies and the responsibilities of the consumer or the personal representative, attendants and agencies under the delegated model.

A. **The consumer's or personal representative's responsibilities** include:

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

(2) taking the medical assessment form (MAD 075) once a year to his/her doctor and submitting it to the TPA or medicaid's alternative designee for review; this must be done as required prior to his/her IPoC LOC expiring to ensure that there will be no break in services; a consumer who does not submit a timely MAD 075 to the TPA or alternative medicaid designee could experience a break in services; in addition, the consumer must allow the alternative medicaid designee to complete assessment visits and other contacts necessary to avoid a break in services; and

(3) complying with all medicaid and program requirements; failure to comply with requirements could result in discontinuation of PCO services.

B. **The consumer-delegated agency responsibilities** include, but are not limited to the following:

(1) employing, terminating and scheduling qualified attendants;

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

(a) an overview of PCO services;

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

(c) cardiopulmonary resuscitation (CPR) and first aid training; and

(d) a written competency test with a minimum passing score of 80 percent or better; expenses for all trainings are to be incurred by the agency; other trainings may take place throughout the year as determined

by the agency; the agency must maintain in the attendant's file copies of all trainings, certifications, and specialty training the attendant completed; CPR and first aid certifications must be kept current;

(i) documentation of all training must include at least the following information: 1) name of individual taking training; 2) title; 3) source of instruction; 4) number of hours of instruction; and 5) date instruction was given;

(ii) documentation of competency testing must include at least the following: 1) name of individual being evaluated for competency; 2) date and method used to determine competency; and 3) copy of the attendant's graded and passed competency test in the attendant's personnel file; special accommodations must be made for attendants who are not able to read or write or who speak/read/write a language other than English;

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

(4) complete instructions regarding the consumer's care and a list of attendant duties and responsibilities must be available in each consumer's residence;

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

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

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

(8) preparing all documentation necessary for payroll;

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

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

(11) verifying every month that all consumers are eligible for full medicaid coverage prior to furnishing services pursuant to Subsection A of 8.302.1.11 NMAC, *provider responsibilities and requirements;* agencies must document the date and method of eligibility verification; possession of a medicaid card does not guarantee a consumer's financial eligibility because the card itself does not include financial eligibility, dates or other limitations on the consumer's financial eligibility; agencies that provide PCO services to consumers who are not financially eligible cannot bill medicaid or the consumer for PCO services rendered to the consumer;

(12) maintaining records that are sufficient to fully disclose the extent and nature of the services furnished to the consumers as outlined in 8.302.1 NMAC, *General Provider Policies*; the PCO agency may elect to keep a log/check-off list, in addition to the time sheet, in the consumer's home, describing services provided on a daily basis; if a log/check-off list is maintained, the log must be compared with the weekly time sheet and copies of both the time sheet and the log/check-off list must be kept in the consumer's file;

(13) passing random and targeted audits, conducted by the department or its audit agent, that ensure agencies are billing appropriately for services rendered; medicaid or its alternative designee will seek recoupment of funds from agencies when audits show erroneous billing or insufficient documentation for services;

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

(15) maintaining appropriate record keeping of services provided and fiscal accountability as required by the MAD 335;

(16) ensuring that each consumer served has a current, approved IPoC on file;

(17) performing the necessary nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act; the agency must ensure that the individual has submitted to a request for a nationwide criminal history screening within 20-calendar days of the individual beginning employment; nationwide caregiver criminal history screening must be performed by an agency certified to conduct such checks; agencies under the consumer-delegated model may conditionally (temporarily) employ an attendant until the national criminal history screening has been returned from the certified agency; if the attendant does not successfully pass a nationwide criminal history screening, the agency may not continue employment;

(18) obtaining from the attendant a signed agreement, in which the attendant agrees that he will not provide PCO services while under the influence of drugs or alcohol and acknowledges that if he is under the

influence of drugs alcohol while providing PCO services he will be immediately terminated; the agency shall not employ an attendant who has previously been terminated from employment for use of drugs or alcohol while providing PCO services;

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

(20) verifying that consumers will not be receiving services through the following programs, while they are receiving PCO services:all HCBS waivers except CoLTS (c) HCBS waiver, medicaid certified nursing facility (NF), intermediate care facility/mentally retarded (ICF/MR), PACE, or ALTSD APS attendant care program; an individual residing in a NF or ICF/MR or receiving community-based services is eligible to apply for PCO services to facilitate NF discharge; all individuals must meet the financial/medical eligibility requirements under PCO to receive PCO services; the TPA, medicaid, or its designee must conduct an assessment or evaluation to determine if the transfer is appropriate and PCO services would be able to meet the needs of that individual;

(21) processing all claims for PCO services; payment shall not be issued without appropriate documentation;

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

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

(24) performing payroll activities for the attendants;

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

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

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

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

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

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

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

(a) death:

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

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

(b) other reportable incidents:

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

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

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

(iv) any report made to APS;

(29) conducting face-to-face supervisory visits in the consumer's residence, once a month at a minimum (12 per service plan year); each visit must be sufficiently documented in the consumer's file;

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

(31) following current recommendations of the state department of health for preventing the transmission of tuberculosis (TB) for attendants upon initial employment and as needed; and

(32) verifying initially prior to employment, and annually thereafter, that attendants are not on the employee abuse registry pursuant to 8.11.6 NMAC and in accord with Employee Abuse Registry Act.

C. **Eligible consumer-delegated agencies:** PCO agencies must be certified by medicaid or its designee. A PCO agency listing, by county, is maintained by medicaid or its designee. All certified PCO agencies are required to select a county in which to establish and maintain an official office for conduct of business with published phone number and hours of operation; the PCO agency must provide services in all areas of the county in which the main office is located. The PCO agency may elect to serve any county within 100 miles of the main office. The PCO agency may elect to establish branch office(s) within 100 miles of the main office. The PCO agency must provide PCO services to all areas of any county(ies) selected to provide services. To be certified by medicaid or its designee, agencies must meet the following conditions and submit a packet (contents 1-6 described below) for approval to medicaid's fiscal agent or its designee containing the following:

(1) a completed medicaid provider participation application (MAD 335);

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

(3) a copy of a current/valid business license or evidence of non-profit status; after certification, a copy of the business license/evidence of non-profit status must be kept current and submitted annually;

(4) proof of liability and workers' compensation insurance; after certification, proof of liability and workers' compensation insurance must be submitted annually to medicaid or its designee;

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

(a) medicaid's PCO provider policies;

(b) personnel policies; and

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

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

(ii) meeting all ADA requirements;

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

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

(i) service delivery;

(ii) operational activities;

(iii) quality improvement action plan; and

(iv) documentation of activities.

(6) a copy of the agency's written competency test for approval to MAD or its designee; an agency may elect to purchase a competency test or it may develop its own test; the test must address at least the following:

(a) communication skills;

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

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

(d) nutrition and meal preparation;

(e) housekeeping skills;

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

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

(h) universal precautions and basic infection control;

(i) home safety including oxygen and fire safety;

(j) incident management and reporting; and

(k) confidentiality;

(7) a copy of a current and valid home health license, issued by the department of health, division of health improvement, licensing and certification (pursuant to 7.NMAC 28.2) may be submitted in lieu of requirements (3), (5) and (6) of this section; after certification, a copy of a current and valid home health license

must be submitted to medicaid or its designee annually along with proof of liability and workers' compensation insurance;

(8) after medicaid or its designee has received and reviewed the packet, the PCO agency will be contacted to complete the rest of the certification process; this will require the PCO agency to:

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

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

(9) any professional authorized to complete the medical assessment form (MAD 075) under the PCO program cannot also become a personal care agency.

D. **The consumer-delegated personal care attendant responsibilities and requirements include:**

(1) being hired by the PCO agency;

(2) not being the spouse or minor child of the consumer pursuant to 42 CFR Section 440.167 and CMS state medicaid manual section 4480-D;

(3) providing the PCO agency with proof of and copies of current/valid driver's license or current/valid photo ID and if the attendant will be transporting the consumer, current/valid driver's license and current motor vehicle insurance policy;

(4) being 18 years of age or older;

(5) ensuring that if the attendant is the consumer's legal guardian or attorney-in-fact and is the elected individual for hire, prior approval has been obtained from MAD or its designee; any personal care services provided by the consumer's legal guardian or attorney-in-fact *MUST* be justified, in writing, by the PCO agency and consumer and submitted for approval to MAD or its designee prior to employment; the justification must demonstrate and prove the lack of other qualified attendants in the applicable area; documentation of approval by MAD or its designee must be maintained in the consumer's file and submit appropriate documentation of time worked and services performed ensuring that he/she has signed his/her time sheet/log/check-off list verifying the services provided to the consumer;

(6) successfully passing a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act, performed by an agency certified to conduct such checks; attendants are required to submit to a criminal history screening within the first 20 days of hire; an attendant may be conditionally hired by the agency contingent upon the receipt of written notice from the certified agency of the results of the nationwide criminal history screening; attendants who do not successfully pass a nationwide criminal history screening are not eligible for further PCO service employment;

(7) ensuring while employed as an attendant he will not be under the influence of drugs or alcohol while performing PCO services; the attendant must complete and sign an agreement with the agency in which the attendant acknowledges that if he is under the influence of drugs or alcohol while providing PCO services he will be immediately terminated;

(8) successfully passing a written personal care attendant competency test with 80 percent or better within the first three months of employment;

(9) completing 12 hours of training yearly; the attendant must obtain certification of CPR and first aid training within the first three months of employment, and the attendant must maintain certification throughout the entire duration of providing PCO services; additional training will be based on the consumer's needs as listed in the IPoC; attendants are not required to be reimbursed for training time; and

(10) following current recommendations of the centers for disease control and prevention (CDC) for preventing the transmission of tuberculosis (TB).

[8.315.4.11 NMAC - Rp, 8.315.4.11 NMAC, 9-15-10]

8.315.4.12 ELIGIBLE POPULATION: Consumers receiving personal care services must meet all of the following criteria:

A. be on a full benefit medicaid category and not be receiving medicaid home and community-based waiver (HCBW) services, (except for CoLTS (c) waiver services), medicaid nursing facility (NF), intermediate care facility/mentally retarded (ICF/MR), PACE, or ALTSD APS attendant care program , at the time PCO services are furnished; an individual residing in a NF or ICF/MR or receiving community-based services is eligible to apply for PCO services to facilitate NF discharge; all individuals must meet the fmedicaid financial/medical eligibility requirements am to receive PCO services; the TPA, medicaid or its alternative designee must conduct an assessment

or evaluation to determine if the transfer to PCO is appropriate and if the PCO program would be able to meet the needs of that individual;

B. be age 21 or older; be determined to have met the LOC of care required in a nursing facility by the TPA or medicaid's designee;

C. have an approved IPoC, developed by the consumer or personal representative, in conjunction with PCO agency or medicaid's designee; and

D. comply with all medicaid and program policies and procedures.

[8.315.4.12 NMAC - Rp, 8.315.4.12 NMAC, 9-15-10]

8.315.4.13 COVERAGE CRITERIA: PCO services are defined as those tasks necessary to maintain a consumer's physical, social or cognitive functional ability to avoid institutionalization, maintain or increase the consumer's functional level, and maintain or increase the consumer's independence. PCO services do not provide services 24 hours per day. PCO services are allocated for a reasonable accommodation of tasks, but does not provide 24-hours per day services. Average time for an ADL or IADL will be based on industry average allocation of time for an individual at the same LOC and with similar conditions or primary diagnosis. Services are covered under the following criteria.

A. PCO services are usually furnished in the consumer's place of residence, except as otherwise indicated, and during the hours specified in the consumer's IPoC. If a consumer is a resident in an assisted living facility, shelter home, or room and board facility, the TPA or alternative medicaid designee, will perform an assessment and ensure that the PCO services do not duplicate the services that the facility is providing. The facility must be able to prove that ADLs are not part of the services the resident is paying for and provide a copy of the service contact or admission agreement signed by the consumer, before the need for PCO services can be assessed. Regulations for assisted living facilities may be found at 7.8.2 NMAC, *Requirements for Adult Residential Care Facilities*. Services may be furnished outside the residence only when appropriate and necessary and when not available through other existing benefits and programs, such as home health or other state plan or long-term care services.

B. PCO services are not furnished to an individual who is an inpatient or resident of a hospital, nursing facility, ICF/MR, mental health facility, correctional facility, other institutional settings or an assisted living facility, shelter home or room and board facility that provides assistance with ADLs as determined in Subsection A of 8.315.4.13 NMAC.

C. PCO services are furnished as approved and limited by PCO service regulations and policy to consumers who are unable to perform some/all ADLs or IADLs because of a disability or a functional limitation(s).

D. Consumers who share living space will be assessed and allocated services pursuant to Subsection L of 8.315.4.14 NMAC to avoid unnecessary duplication of services. If a consumer's living situation changes:

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

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

E. Consumers, who do not live alone, and share a residence with other family members not receiving services under the program will be assessed for, among other factors, the natural supports in the household, to determine if they are eligible to receive services under the specified categories under 8.315.4.14 NMAC.

F. All consumers, regardless of living arrangements, will be assessed for natural supports. PCO services are not intended to replace natural supports.

[8.315.4.13 NMAC - Rp, 8.315.4.13 NMAC, 9-15-10]

8.315.4.14 COVERED SERVICES: PCO services are provided as described in Subsections A through K. Consumers will be assessed both individually and jointly, as appropriate (Subsection L), in each of the following listed service categories. Consumers who are not assessed as having a need in that service category will not be allocated services in that category.

A. **Individualized bowel and bladder services:** These services do not have to be performed by a nurse pursuant to NMSA 1978, Section 61-3-29(J) of the Nursing Practice Act. Bowel and bladder services may be "performed by a personal care provider in a non-institutional setting of bowel and bladder assistance for an individual whom a health care provider certifies is stable, not currently in need of medical care and able to communicate and assess his own needs." Services include:

(1) adult disposable brief changes used for incontinence episodes;

(2) bladder care - cueing consumer to empty bladder at timed intervals to prevent incontinence; elimination; catheter care, including the changing and cleaning of catheter bag; an individual requiring assistance with bladder care must be determined medically stable by his/her physician, and able to communicate his/her bladder care; a consumer who does not have a statement by his/her physician determining he/she is medically stable and able to communicate his/her bladder care needs is not eligible for hours in this category; insertion/extraction of a catheter is not a covered service;

(3) bowel care - evacuation and ostomy care, changing and cleaning of bag and ostomy site skin care; the requirements and limitations from (2) bladder care, regarding medically determined stability and ability to communicate, apply here; digital stimulation is not a covered service;

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

(5) changing of wet or soiled clothing after incontinence episode or assisting with adjustment of clothing before and after toileting.

B. **Meal preparation and assistance:** At the direction of the consumer or his/her personal representative, prepare meal(s) (includes cutting ingredients to be cooked, cooking of meals, and placing/presenting meal in front of consumer to eat, and cutting up food into bite-sized portions) for the consumer or assist the consumer pursuant to the IPoC. This does not include assistance with eating. This includes provision of snacks and fluids and may include cueing consumer to prepare meals. Services requiring assistance with eating are covered under eating in Subsection G of 8.315.4.14 NMAC below.

C. **Support services:** Provide additional assistance to the consumer in order to promote his/her independence and enhance his/her ability to live in the community and remain in a clean and safe environment, particularly a consumer living alone who may not have adequate support. These services include:

(1) shopping or completing errands for the consumer, with or without the consumer;

(2) transporting and assisting with transfers in/out vehicles to non-medically necessary events; if the consumer's vehicle is used, the consumer must have a copy of his/her motor vehicle insurance policy; PCO agencies are not required to provide escort or transportation services; if the consumer requires transportation and the PCO agency cannot meet this need, the PCO agency must refer the consumer to personal care agencies that can meet this need; the TPA or medicaid designee will assess the consumer's formal and informal support systems and determine the availability of other transportation or other agencies such as a medicaid enrolled transportation provider for transportation to medical services; the TPA or medicaid designee will approve transportation services primarily for non-medical transportation, unless the consumer resides in a rural area and does not have access to a medicaid-enrolled transportation provider for medical-related transports; completes the transfer process to another PCO agency as outlined in 8.315.4.19 NMAC; medically necessary transportation services are not covered as personal care option services.

(3) assistance with feeding and hydrating or cueing consumer to feed and hydrating an assistance animal; a consumer must have an assistance animal and be able to verify the animal is an assistance animal and not a pet; feeding and hydrating of pets is not an approved service.

D. **Hygiene/grooming**: The IPoC may include the following tasks to be performed by the attendant. These services include:

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

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

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

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

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

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

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

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

F. **Mobility assistance:** Assistance includes:

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

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

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

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

G. **Eating:** Feed or assist feeding consumer a prepared meal with a utensil or with specialized utensils. Eating is the ability to physically put food into mouth, chew and swallow food safely. The attendant shall assist the consumer as determined by the IPoC. This does not include preparation of food/meals. Eating assistance may include cueing a consumer to ensure appropriate nutritional intake or monitor for choking. Services requiring preparation of food/meals is covered under meal preparation and assistance in Subsection B of 8.315.4.14 NMAC. If the consumer has special needs in this area, the attendant should receive specific instruction to meet that need. Gastrostomy feeding and tube feeding are not covered services.

H. **Assisting with self-administered medication:** This service is limited to *prompting and reminding only*. The ability to self-administer is defined as the ability to identify and communicate medication name, dosage, frequency and reason for the medication. A consumer who does not meet this definition of ability to self-administer is not eligible for this category. A consumer who needs assistance with taking self-administered medication as a reasonable accommodation under the ADA due to a disability may receive assistance as per the IPoC, if the consumer can self-administer medications as defined above. This assistance does not include administration of injections, which is a skilled/nursing task. Assistance includes:

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

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

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

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

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

J. **Cognitive assistance:** Cognitive assistance is intended to keep the consumer on task, and increase or maintain the consumer's safety, for consumer safety, and to increase or maintain independence, and quality of life (e.g., prevent from wandering). This service is primarily for a consumer with a brain injury, alzheimer's disease, mental illnesses, dementia, developmental delay or a consumer who has suffered a stroke/cerebrovascular accident (CVA); a consumer with medical documentation of moderate to severe cognitive deficits; a consumer who does not have one of these diagnoses is not eligible to receive services in this category; those individuals who require prompting and cueing to complete the ADLSs and IADLs are allotted time within a specific service; supervision and companionship are not covered services.

K. **Household services:** This service assists the consumer in performing interior household activities as needed. Such activities are limited to the maintenance of the consumer's personal living area (i.e., kitchen, living room, bedroom, and bathroom). To maintain a clean and safe environment for the consumer, particularly a consumer living alone who may not have adequate support in his/her residence. Services include:

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

(2) dusting the consumer's furniture;

(3) changing the consumer's linens;

(4) washing the consumer's laundry;

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

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

L. **Shared households/living space**: Two or more consumers living in the same residence, (including assisted living facilities, shelter homes, and other similar living arrangements), who are receiving PCO services will be assessed both individually and jointly to determine services that are shared. Consumers sharing living space will be assessed as follows for services identified in Subsections B, C and K of 8.315.4.14 NMAC:

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

(2) jointly with other household members to determine shared living space and common needs of the household; services will be allocated based on common needs, not based on individual needs, unless it has been assessed by the TPA or medicaid alternative designee, there is an individual need for provision of the service(s); (common needs may include meals that can be prepared for several individuals; shopping/errands that can be done at the same time; laundry that can be done for more than one individual at the same time; dusting and vacuuming of shared living spaces), PCO services allocated under these categories are based on the assessment of combined needs in the household without replacing natural and unpaid supports identified during the assessment.

[8.315.4.14 NMAC - Rp, 8.315.4.14 NMAC, 9-15-10]

8.315.4.15 NON-COVERED SERVICES: The following services are not covered as New Mexico medicaid PCO services:

A. services that require professional or technical training;

B. services that, due to the consumer's specialized medical needs, must be provided by a person with professional or technical training to avoid placing the consumer at risk;

C. services that are duplicative of other PCO services, such as billing for the individual provision of services to consumers who share living space and are allocated service hours on a proportional basis or other resources, such as hospice, assisted living, shelter home, or room and board facility;

D. services not approved in the consumer's approved IPoC;

E. childcare or personal care for other household members;

F. retroactive services;

G. services provided to a consumer who does not have medicaid eligibility;

H. assistance with finances and budgeting;

I. scheduling of appointment for a consumer; and

J. range of motion exercises.

[8.315.4.15 NMAC - Rp, 8.315.4.15 NMAC, 9-15-10]

8.315.4.16 THIRD-PARTY ASSESSOR (TPA): The TPA is responsible for making LOC determinations based on criteria developed by medicaid according to national standards (see Attachment II of 8.312.2-UR, *long term care services utilization review instructions for nursing facilities,* available upon request from medicaid). The TPA is responsible for making utilization reviews for all PCO fee-for-service consumers and medicaid's CoLTS MCO is responsible for making utilization reviews for all PCO managed care consumers. The TPA (for fee-for-service) (for FFS PCO) or medicaid's CoLTS MCO (for managed care) is responsible for issuing prior authorizations. Annually, the TPA or other medicaid designee will provide a detailed explanation of the consumer-directed and consumer-delegated models of PCO services delivery. The TPA is not authorized to contract with any medicaid approved PCO agency to carry out TPA responsibilities. The TPA's responsibilities are described below.

A. **Level of care (LOC):** To be eligible for PCO services, a consumer must meet the level of care required in a nursing facility; the CoLTS MCO, the TPA, or other medicaid designee, must contact the consumer within a minimum of 90 days, prior to the expiration of the approved LOC. The TPA or other medicaid designee must begin the LOC determination process for PCO services, to ensure the consumer does not experience a break in PCO services, see Attachment II of 8.312.2-UR, *long term care services utilization review instructions for nursing facilities*. A LOC packet is developed and submitted to the TPA, or other medicaid designee and approved by the TPA, or other medicaid designee.

(1) The LOC packet must include:

(a) a current (within the last six months) approved medical assessment form signed by a physician, physician assistant, nurse practitioner or, clinical nurse specialist;

(b) any other information or medical justification documenting the consumer's functional abilities; and

(c) an assessment of the consumers functional needs, performed by either the TPA or CoLTS MCO, or other medicaid designee.

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

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

(b) approve the consumer's LOC for a maximum of one year (12 consecutive months); and a new LOC determination must be made annually to ensure the consumer continues to meet medical eligibility criteria for PCO services; each LOC determination must be based on the consumer's current medical condition and need of service(s) and may not be based on prior year LOC determinations; and

(c) contact consumer within a minimum of 90 days, prior to the expiration of the approved LOC, to begin the re-assessment process for PCO services.

B. **In-home assessment:** The TPA or medicaid's CoLTS MCO, or other medicaid designee must:

(1) perform an assessment of the consumer's functional needs, in the consumer's place of residence;

(2) explain both service delivery models, consumer-directed and consumer-delegated to the consumer or his/her personal representative and provide the consumer or his/her personal representative with informational material, allowing the consumer to make the best educated decision possible regarding which model he/she will elect. A copy of the consumer's or personal representative's responsibilities in Subsection A of 8.315.4.10 NMAC or Subsection A of 8.315.4.11 NMAC must be provided to each consumer or personal representative, at every annual assessment, based on the service delivery model he/she has elected; and

(3) jointly assess consumers that share living space for meal preparation, assistance services, support services and household services and allocate time based on the assessment of common needs of the household; documentation must be submitted and the individual assessment must support the medical or individual need for provision of these services; the TPA, or medicaid's CoLTS MCO, or other medicaid designee must take into consideration natural and unpaid supports for a consumer who resides with other family members and determine if he/she is eligible to receive services pursuant to identified categories under 8.315.4.14 NMAC.

C. A PCO agency that does not agree with the LOC determination made by the TPA or MAD's designee:

(1) may request a re-review or reconsideration pursuant to medicaid oversight policies, 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953]; and

(2) is responsible for submitting the additional medical justification to the TPA or MAD's designee and adhering to the timelines as outlined in medicaid oversight policies, 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

D. A consumer that does not agree with the LOC determination made by the TPA, CoLTS MCO or other medicaid designee may request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings*. Consumers enrolled in a CoLTS MCO who disagree with authorized number of hours may also utilize the CoLTS MCO grievance and appeal process.

E. Agencies that have identified a consumer with a declining health condition or whose needs have changed and believe the consumer is in need of more or fewer services should notify the TPA or MAD's designee in writing for an additional assessment or LOC determination.

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

[8.315.4.16 NMAC - Rp, 8.315.4.16 NMAC, 9-15-10]

8.315.4.17 INDIVIDUAL PLAN OF CARE (IPoC): An IPoC is developed and personal care services are identified, in conjunction with the independent in-home assessment (MAD 075), *The PCO Assessment Form)* or other approved assessment form. The PCO agency develops an IPoC using an authorization, task list, and natural support information provided by the TPA, CoLTS MCO or other medicaid designee. The finalized IPoC contains approved daily tasks, for a period of seven days at a time, to be performed by the attendant based on the consumer's daily needs. Only those services identified as IADLs may be moved to another day within a seven-day IPoC. Any tasks not performed by the attendant for any reason cannot be banked or saved for a later date.

A. The TPA, CoLTS MCO or other medicaid designee will:

(1) provide authorized hours, task and natural support information for the PCO agency to develop an IPoC in conjunction with the consumer or his/her personal representative; participation in the development of an IPoC is not separately reimbursable for consumers or his/her personal representative;

(2) jointly assess consumers that share living space for meal preparation, assistance services, support services and household services and allocate appropriate proportions to each consumer according to the common needs of the household and the number of consumers sharing the services.

B. The PCO agency must:

(1) develop the IPoC and include the following:

(a) a specific description of the attendant's responsibilities, including tasks to be performed b y the attendant and any special instructions related to maintaining the health and safety of the consumer; and

(b) a prior authorization (PA) number issued to the agency of the consumer's choice for on-going billing purposes; a healthcare common procedure coding system (HCPCS) code must be tied to the PA based on the consumer's elected model of service delivery;

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

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

(4) provide the consumer with a copy of their approved IPoC;

(5) contact consumer within a minimum of 90 days, prior to the expiration of the approved IPoC, to begin the re-assessment process for PCO services, to ensure the consumer does not experience a break in PCO services;

(6) obtain an approved task list/PA from the TPA or medicaid CoLTS MCO designee;

(7) refer consumers to the TPA, or medicaid's CoLTS MCO, or other medicaid designee who do not ensure the consumer has participated in the development of the plan and that the IPoC indicates that the consumer or the consumer's personal representative a signature on the IPoC indicates that the consumer or the consumer's personal representative understands what services have been identified and that services will be provided on a weekly basis for a maximum of one year; if the consumer is unable to sign the IPoC and the consumer does not have a personal representative, a thumbprint or personal mark (i.e., an "X") will suffice; if signed by a personal representative, the medicaid's designee and the agency must have documentation in the consumer's file verifying the individual is the consumer's personal representative; utilize services or the full amount of allocated services on the IPoC for review; documentation must be in the consumer's file demonstrating that a consumer has not utilized the full amount of hours allocated on the IPoC; and

(8) submit a personal care transfer/closure form (MAD 062 or other approved transfer/closure form) to the TPA, CoLTS MCO or other medicaid designee to close out a consumer's PCO who has passed away or who has not received services for 90 consecutive days.

C. PCO services are to be delivered in the state of New Mexico only. Consumers who require PCO services out of the state, for medically necessary reasons only, must obtain ALTSD PCO approval prior to leaving the state. The following must be submitted for consideration to the program when requesting medically necessary out-of-state services:

(1) a letter from the PCO agency requesting an out-of-state exception and reason for request; the letter must include:

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

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

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

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

(2) a letter or documentation from the physician or surgeon verifying the date of the medical procedure; and

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

[8.315.4.17 NMAC - N, 9-15-10]

8.315.4.18 PRIOR APPROVAL AND UTILIZATION REVIEW (UR): All personal care services are subject to utilization review for medical necessity and program compliance. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. All personal care services require prior LOC approval by medicaid's designated TPA/UR contractor; therefore, retroactive services are not authorized. All PCO services provided through a medicaid CoLTS MCO designee shall then be authorized by the MCO in which the consumer is enrolled.

A. The medicaid designated TPA/UR contractor will perform utilization review for medical necessity. The TPA/UR contractor or the medicaid CoLTS MCO designee makes final authorization of PCO services using:

(1) the TPA-approved LOC determination; and

(2) an assessment conducted by the TPA/UR contractor or medicaid CoLTS MCO designee.

B. The PCO agency must obtain an approved task list and prior authorization number from the medicaid designated TPA/UR contractor or medicaid CoLTS MCO designee to ensure the consumer has been approved to receive PCO services.

C. Services for which prior approval was obtained remain subject to utilization review at any point during the consumer's plan year.

D. Prior approval of services does not guarantee that an individual is eligible for medicaid. PCO agencies must verify monthly all individuals' financial eligibility for medicaid prior to providing services.

E. A PCO agency that does not agree with prior approval, denials or other review decisions made by any medicaid designee:

(1) may request a re-review or reconsideration pursuant to medicaid oversight policies, 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953]; and

(2) is responsible for submitting the additional information and medical justification to the medicaid's designated TPA/UR and adhering to the timelines outlined in medicaid oversight policies, (as cited above).

F. A consumer who does not agree with prior approval, denials or other review decisions made by the TPA or medicaid's designee may request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings.* Consumers enrolled with a CoLTS MCO who disagree with authorized number or type of services may also utilize the CoLTS MCO grievance and appeal process.

[8.315.4.18 NMAC - Rp, 8.315.4.17 NMAC, 9-15-10]

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

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

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

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

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

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

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

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

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

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

(9) there is reason to believe that solicitation has occurred as defined in 8.315.4.22 NMAC, *reimbursement.*

B. The TPA/UR contractor (for FFS PCO) or the medicaid CoLTS MCO designee (for managed care) will notify the consumer, the TPA and both the originating agency and the receiving agency of its decision and has 15-working days after receiving the request from the TPA to make a decision. The consumer must work with the medicaid TPA/UR contractor or medicaid CoLTS MCO designee to verify their request.

C. A consumer who does not agree with the decision may request a fair hearing pursuant to 8.352.2 NMAC, *Recipient Hearings.* The originating agency is responsible for the continuance of PCO services throughout the fair hearing process. Consumers enrolled with a CoLTS MCO who disagree with authorized number of hours may also utilize the CoLTS MCO grievance and appeal process.

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

(1) The consumer must inform their CoLTS MCO of the desire to transfer PCO agencies; the CoLTS MCO approves or denies requested transfer; if approved, the CoLTS MCO works with both the agency he/she is currently receiving services from (originating agency) and the agency he/she would like to transfer to (receiving agency) about the transfer request to effect the transfer; consumers in FFS PCO must request a PCO agency transfer through the TPA/UR contractor.

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

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

(4) After CoLTS MCO verification of consumer's request, medicaid's CoLTS MCO designee will process the transfer request within 15 working days of receiving the transfer request. For FFS PCO transfer requests, the TPA/UR contractor will verify and process.

(5) Medicaid's CoLTS MCO designee or TPA/UR contractor will issue a new prior authorization number to the receiving agency and make the transfer date effective 10 business days from the date of processing the transfer request with new dates of service and units remaining for the remainder of the IPoC year; medicaid's CoLTS MCO designee or TPA/UR contractor will notify the consumer and the originating and receiving PCO agencies.

[8.315.4.19 NMAC - Rp, 8.315.4.18 NMAC, 9-15-10]

8.315.4.20 CONSUMER DISCHARGE PROCESS BY PCO AGENCY: The PCO agency may discharge a consumer for a justifiable reason. Prior to initiating discharge, the PCO agency must send a notice to medicaid or its designee for approval. Once approved by medicaid or its designee, the PCO agency may initiate the discharge process by means of a 30-day written notice to the consumer. The notice must include the consumer's right to request a fair hearing and must include the justifiable reason for the agency's decision to discharge.

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

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

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

(3) a consumer or family member demonstrates a pattern of uncooperative behavior including not complying with agency or medicaid policy; not allowing the PCO agency to enter the home to provide services; and continued requests to provide services not approved on the IPoC;

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

(5) fraudulent submission of timesheets; or

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

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

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

[8.315.4.20 NMAC - Rp, 8.315.4.19 NMAC, 9-15-10]

8.315.4.21 CONSUMER DISCHARGE PROCESS BY STATE: Medicaid or its designee reserves the right to exercise its authority to discontinue the consumer's receipt of PCO services due to the consumer's non-compliance with medicaid program requirements. The consumer's discontinuation of PCO services does not affect his/her medicaid eligibility. The consumer may be discharged for a justifiable reason by means of a 30-day written notice to the consumer. The notice will include duration of discharge, which may be permanent, the consumer's right to request a fair hearing, and the justifiable reason for the decision to discharge. A justifiable reason for discharge may include:

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

B. a consumer who demonstrates a pattern of verbal/physical abuse of attendants, agency personnel, or state staff, including use of vulgar/explicit language, verbal or physical sexual harassment, excessive use of force, verbal or physical intimidating threats;

C. a consumer or family member who demonstrates a pattern of uncooperative behavior including, not complying with agency, medicaid program requirements or policies or procedures;

D. illegal use of narcotics or alcohol abuse; and

E. fraudulent submission of timesheets; or

F. unsafe or unhealthy living conditions or environment.

[8.315.4.21 NMAC - N, 9-15-10]

8.315.4.22 REIMBURSEMENT: A medicaid-approved personal care agency will process billings in accordance with the following:

A. Agencies must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, agencies receive instructions on documentation, billing, and claims processing. Claims must be filed per the billing instructions in the medicaid manual. PCO agencies must use ICD-9-CM diagnosis codes when billing for medicaid services.

B. Reimbursement for PCOservices is made at the lesser of the following:

(1) the provider's billed charge;

(2) the MAD fee schedule for the specific service or procedure; or

(3) the agency's billed charge must be its usual and customary charge for services.

(4) "usual and customary charge" refers to the amount an individual provider charges the general public in the majority of cases for a specific service and level of service.

[8.315.4.22 NMAC - Rp, 8.315.4.20 NMAC, 9-15-10]

8.315.4.23 PCO PROVIDER VOLUNTARY DISENROLLMENT: A medicaid approved PCO agency may choose to discontinue provision of services. Once approved by medicaid or its designee, the PCO agency may initiate the disenrollment process to assist consumers to transfer to another medicaid approved PCO agency. The PCO agency must continue to provide services until consumers have completed the transfer process and the agency has received approval from medicaid or its designee to discontinue services. Prior to disenrollment, the PCO agency must send a notice to medicaid or its designee for approval. The notice must include:

A. consumer notification letter;

B. list of all the medicaid approved personal care agencies serving the county in which the consumer resides; and

C. list of all consumers currently being served by the agency and the MCO in which they are enrolled.

[8.315.4.23 NMAC - N, 9-15-10]

8.315.4.24 SOLICITATION/ADVERTISING: For the purposes of this section, solicitation shall be defined as any communication regarding PCO services from an agency's employees, affiliated providers, agents or contractors to a medicaid recipient who is not a current client that can reasonably be interpreted as intended to influence the recipient to become a client of that entity. Individualized personal solicitation of existing or potential consumers by an agency for their business is strictly prohibited. Prohibited solicitation includes but is not limited to the following.

A. Prohibitions under this category include:

(1) contacting a consumer who is receiving services through another PCO program or any another medicaid program;

(2) contacting a potential consumer to discuss the benefits of its agency, including door to door, telephone and email solicitation;

(3) offering a consumer/attendant finder fee, kick back, or bribe consisting of anything of value to the consumer to obtain transfers to its agency; see 8.351.2 NMAC, *Sanctions and Remedies;*

(4) directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing activities by entity's employees, affiliated providers, agents or contractors;

(5) making false promises;

(6) intentional misinterpretion of medicaid policies/procedures/eligibility;

(7) misrepresenting self as having affiliation with another entity; and

(8) distributing PCO related marketing materials.

B. Penalties for engaging in solicitation prohibitions: Agencies suspected of solicitation will be put on moratorium during the investigation or review period. Agencies found to be conducting such activity will be subject to monetary penalty or termination of its provider participation agreement (MAD 335).

C. An agency wishing to advertise or conduct any type of community outreach for PCO service provision, or its agency must first get prior approval from medicaid or its designee before conducting any such activity. Advertising and community outreach materials means materials that are produced in any medium, on behalf of a PCO agency and can reasonably be interpreted as advertising to potential clients. Advertising or community outreach materials must not:

(1) misrepresent the agency as having affiliation with another entity;

(2) use proprietary titles, such as "medicaid PCO".

D. Any PCO agency conducting any such activity without prior approval from medicaid or its designee may be subject to moratorium, a civil monetary penalty or have its medicaid provider participation agreement (MAD 335) terminated for conducting such activity without prior approval. During a moratorium an agency shall not acquire any new consumers but may continue to provide services to its existing consumers. [8.315.4.24 NMAC - N, 9-15-10]

8.315.4.25 OTHER:

A. An attendant may not act as the consumer's personal representative, in matters regarding medical treatment, financial or budgetary decision making, unless the attendant is the consumer's legal guardian, agent under a power of attorney, conservator, or representative payee. If the agency questions whether the consumer is able to direct his/her own care, an agency must make a referral to an appropriate social service or legal agency(s) for assistance.

B. An agency that is non-compliant with provider requirements or medicaid or program policies or procedures may be placed on moratorium by medicaid or its designee until the PCO agency has demonstrated, to the satisfaction of medicaid or its designee, full compliance with all requirements of policies and procedures.

C. An agency wishing to advertise or conduct any type of community outreach for PCO services or its agency must first get prior approval from MAD or its designee before conducting any such activity. An agency conducting any such activity without prior approval from MAD or its designee may be subject to moratorium, civil monetary penalty or have its medicaid provider participation agreement (MAD 335) terminated for conducting such activity without prior approval. During a moratorium an agency shall not acquire any new consumers but may continue to provide services for its existing consumers.

D. An agency may not deceive or misrepresent information to a potential PCO consumer. An agency conducting any such activity may be subject to moratorium, a civil monetary penalty or termination of its provider participation agreement (MAD 335). Agencies who are suspected of or being investigated or reviewed by MAD or its designee for any of the below activities may be put on moratorium by MAD or its designee during the period of investigation or review. This includes:

(1) contacting a consumer who is receiving services through another medicaid program, including PCO services;

(2) any kind of solicitation, including door to door, of potential consumers;

(3) making false promises;

(4) misrepresenting medicaid policies/procedures/eligibility; and

(5) representing itself as an entity to which it has no affiliation.

E. Individualized personal solicitation of existing or potential consumers by an agency for their business is strictly prohibited. Agencies suspected of solicitation will be put on moratorium during the investigation or review period. Agencies found to be conducting such activity will be subject to monetary penalty or termination of its provider participation agreement (MAD 335). Prohibited solicitation includes but is not limited to:

(1) contacting a consumer who is receiving services through PCO or any other medicaid program;

(2) contacting a potential consumer to discuss the benefits of its agency, including door-to-door, telephone and email solicitation; and

(3) offering a consumer/attendant finder fee, kick back, or bribe consisting of anything of value to the consumer to obtain transfers to its agency. See 8.351.2 NMAC, *Sanctions and Remedies.*

[8.315.4.25 NMAC - Rp, 8.315.4.21 NMAC, 9-15-10]

HISTORY OF 8.315.4 NMAC:

History of Repealed Material:

8 NMAC 4.MAD.738, Personal Care Services, filed 8/18/1999 - Repealed effective 7/1/2004.

8.315.4 NMAC, Personal Care Option Services, filed 6/16/2004 - Repealed effective 9/15/10.